Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 29, 2018	2018_742527_0012	034855-16, 008479-17, 014536-17, 015149-17, 029751-17, 005151-18, 006209-18, 011523-18	Complaint

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Creedan Valley Care Community
143 Mary Street CREEMORE ON L0M 1G0

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

KATHLEEN MILLAR (527), AMANDA COULTER (694), SHARON PERRY (155)

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): June 4, 5, 6, 7, 8, 11, 12, 13, 15, 18, 19, 21 and 22, 2018.

The following Complaint Inspections were conducted:

Log #034855-16, related to improper care;
Log #008479-17, related to alleged neglect;
Log #014536-17, related to improper pain management;
Log #0015149-17, related to environmental and maintenance issues;
Log #029751-17, related to no registered nurse on duty;
Log #005151-18, related to plan of care and nutrition concerns;
Log #006209-18, related to no fire sprinklers, emergency plans, bathing & nursing/support services; and
Log #011253-18, related to nursing and support services concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), the Resident Relations Coordinator, the Food Services Supervisors, the Programs Manager, the Administrative Manager, the Resident Assessment Instrument (RAI) Coordinator, the Nurse Practitioner (NP), the Behavioural Support Ontario (BSO) Registered Nurse (RN), BSO Registered Practical Nurse (RPN) and BSO Personal Support Worker (PSW), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Care Support Assistants (CSAs), Registered Dietitian (RD), Physiotherapist (PT), physiotherapy aide (PTA), maintenance staff, environmental services aides, dietary aides, activities staff, office clerks, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

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

16 WN(s)
7 VPC(s)
7 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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 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 of the home was on duty and present in the home at all times, except as provided for in the regulations.

An anonymous complaint was received stating that the home had no Registered Nurse (RN) in the home on two specific dates in 2017. Another complaint was received stating that on a specific date in 2017, the home was scheduling agency Registered Nurses (RN) to work a specific shift.

A review of the registered staff schedules was completed, which included approximately a six month period from 2017 to 2018. The review showed that agency RNs worked numerous shifts during the six month period.

The schedules reviewed from 2017 to 2018, also showed that there was no RN on duty and present in the home on a specific date and time in 2017. The shift was worked by a Registered Practical Nurse (RPN).

During an interview with the Director of Care (DOC) #101, they shared that they used agency staff and that they were currently recruiting for a part time RN position. They shared the goal was to limit the use of agency RNs. A review of RN schedules was completed with the DOC #101. The DOC#101 shared that during specific shifts there were no RPNs working.

Review of the home's annual staffing plan evaluation for 2017, identified a goal to decrease agency usage within the home.

The licensee 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 of the home was on duty and present in the home at all times, except as provided for in the regulations.

This area of non-compliance was identified during a Complaint Inspection, log #029751-17.

The licensee 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 of the home was on duty and present in the home at all times, except as provided for in the regulations.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the residents' equipment were kept clean and sanitary.

Resident #006's, #010's, and #016's mobility equipment was observed during this inspection as being soiled. The residents' equipment remained soiled throughout the inspection.

The licensee's policy titled "Equipment Maintenance and Cleaning - Nursing and Resident Care", did not include a schedule for cleaning of specific resident equipment.

(i) Resident #006's clinical record identified no task for cleaning for this resident's equipment during specific months in 2018.

(ii) Resident #010's equipment was observed soiled throughout the inspection. Review of the resident's clinical record identified that for a three month period during 2018, the resident's equipment was cleaned three times.

(iii) Resident #016's equipment was observed during the course of the inspection and it remained soiled. Review of the resident's clinical record for a three month period in 2018,

identified that there was no documentation that the equipment was cleaned.

The DOC was interviewed and acknowledged that they were not able to locate resident #006's equipment cleaning schedule and that resident #010 and #016, were scheduled for their equipment cleaning each week. The DOC indicated that it was an expectation that PSW staff on a specific shift were to clean residents' equipment once a week according to the schedule in POC and this did not occur.

The licensee failed to ensure that the residents #006, #010 and #016 had their equipment, kept clean and sanitary.

2. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On a specific day and month in 2018, resident #016’s window was covered up with drywall that was secured in place. Resident #016 was observed to be sitting in their mobility device next to the covered window.

Resident #016 was interviewed and shared that the window was covered up as it was broken. When asked how long it had been broken resident #016 shared that it had been broken for a few years. Resident #016 had not been told when the window would be fixed.

Personal Support Worker (PSW) #110 was interviewed and shared that the window next to resident #016 was covered up with drywall and secured because the window was broken. They shared that it had been like that since last summer.

PSW # 112 was interviewed and shared that the window next to resident #016 had been broken for a couple of years.

The Maintenance aide #117 was interviewed and shared that the window next to resident #016 had been covered with drywall and secured in place when they started working in the home in a specific month in 2017.

On a specific date in 2018, the Maintenance aide#117 shared that they had removed the window and window frame next to resident #016 and had taken it to be repaired. The window opening next to resident #016 was noted to be covered with a piece of plywood.

When this inspection was completed, on a specific date in 2018, the window opening next to resident #016 was observed to still be covered with plywood.

The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

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 LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents’ Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home’s mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home’s policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home’s policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person’s responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff at the home had received training before performing their responsibilities as required by this section.

A review of the home's staff schedules and Vacant Hours Reports showed that the home used agency RNs, RPNs and PSWs.

A review of the Registered Staff schedules was completed for a seven month period in 2017 and 2018. The review showed that agency RNs #151, #152, #153, #154, #155, #156, #157, #158 and #159, worked during the seven month period between 2017 and 2018. The review showed that agency RPNs #103, #147, #160, #161 and #162, also worked during this time.

A review of the Vacant Hours Reports for a three month period in 2018 showed that agency PSWs worked a specific number of hours during this period.

The DOC #101 was interviewed and shared that during the three month period in 2018, agency RNs worked a specific number of hours and agency RPNs worked a specific number of hours. They shared that agency staff received orientation and that the Administrative Manager was the designated lead for the training and orientation program.

The Administrative Manager #149 was interviewed and shared the agency education records. Review of these records was completed and showed that in 2017, agency staff were offered to review the following:

• Prevention of Abuse and Neglect of a Resident Policy, revised January 2015;
• Vision, Mission and Values;
• Employee conduct Policy, revised March 2015;
• Accessibility for Ontarian's with Disabilities Act Policy, revised November 2017;
• Confidentiality Agreement;
• Zero Lift Protocol and Statement of Understanding;
• The Chain of Disease Transmission Policy, revised May 2016; and
• The Residents’ Bill of Rights.

Review showed that agency RN #153, #154, #155, #156, #157, #158 and #159 had not completed any of the above education. Review showed that agency RPN #103, #160, #161 and #162 had not completed any of the above education.

The Administrative Manager #149 said that if they know that an agency staff were coming in to work they have them come and review the documents, but often agency come in for specific shifts and they did not review the documents.

The DOC #101 provided one additional file that was for agency RN #152. Agency RN #152, had no documented evidence that the Residents' Bill of Rights, the licensee's policy to minimize the restraining of residents, fire prevention and safety, emergency and evacuation procedures, infection prevention and control and medication management system orientation had been provided.

Agency RPN #147, shared that they could not recall if that had received any orientation. RPN #147 shared that they had not received any education on fire prevention and safety, or emergency and evacuation procedures.

The DOC #101 shared that they felt agency staff were being orientated; however they had no more documentation to support this. They had no records to support that any agency staff had received fire prevention and safety, or emergency and evacuation procedure training before performing their responsibilities.

The licensee failed to ensure that all staff at the home had received training before performing their responsibilities as required by this section.

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the written staffing plan for the nursing and personal support services programs provided for a staffing mix that was consistent with residents' assessed care and safety needs.

An anonymous complaint was received by the Ministry of Health and Long Term Care (MOHLTC) Infoline regarding residents being woke up for care during a specific shift and that baths were not getting done because of nursing shortages in the home.

Another anonymous complaint was received by the MOHLTC Infoline regarding PSW shortages in the home, that the home hired Care Support Assistants (CSA) to assist, and they were concerned about the lack of care the residents were receiving.

During this inspection, PSWs #113, #118, #123, #124, #125 and #132, all shared that they often had to work short, the staff scheduled to do the bathing shifts were being reassigned to the floor to provide primary care, thus resulting in residents not receiving their baths, and CSAs had been hired to help; however they were not able to provide any personal care or see any residents unless they were dressed.

During this inspection, CSAs #122, #136 and #137 shared that they were hired to assist the PSWs. They shared that their duties included making beds, emptying laundry and garbage, serving and feeding meals to residents, serving and assisting residents with nourishment cart, being a second person in a two-person transfer, portering residents to meals and activities. They all shared that they did not provide any personal care of bathing, toileting, or dressing, as they were not allowed to see any residents that were not dressed. They shared that they had no access to Point of Care, so could not do any documentation of food or fluids they had given to residents nor could they see the resident care plans or kardex.

During an interview with Administrator #100, they shared that they had hired eight CSAs, that started on a specific date in 2018. They shared that they were hired as the home was experiencing a shortage of PSWs. They shared that there was a shortage of PSWs within their Local Health Integration Network (HIN) and that Georgian College had not been able to offer the PSW program because they did not have enough applicants.

During this inspection, record review showed that resident #014, #015 and #019 had not been bathed, at a minimum, twice a week by the method of their choice, including tub baths, showers, and full body sponge baths.

During this inspection, resident #005 also expressed concerns that they were not always getting their showers as the home was short of staff. They shared that they did not get their shower on a specific date in 2018. Resident #021, also expressed that they had missed getting baths and that they did not get their bath on a specific date in 2018. Record review showed that there was no documentation in point of care showing that resident #005 and #021, was provided with their shower or bath on the specific dates they identified in 2018.

Review of point of care documentation showed that residents #016, #023, #024, #025, #026, #027, #028, #029, #030 and #031, did not receive their bath or shower. DOC #101 shared that the staff working the bathing shifts were reassigned to work on the floor on a specific date in 2018.

Review of the home’s staffing plan compliment for a 24 hour period for PSWs was completed and a review of the Vacant Hours Reports for a three month period in 2018, was completed and identified there was vacant PSW hours during the three month period.

It was noted that as of a specific date in 2018 and each report after that date included the CSA hours; therefore making the total vacant PSW hours not a true reflection of total vacant PSW hours.

During an interview with DOC #101, they shared that they allow CSAs to work on two specific shifts to a maximum of two CSAs on each of those shifts. They shared that if they could not schedule the full complement of PSWs on specific shifts, they would also schedule two CSAs. They shared that they do not call for agency PSWs unless they were more than two PSWs short on each shift.

During an interview with PSW #123, they shared that they were told that they were fully staffed; however that was only if the CSAs were counted as part of the PSW staff.

During an interview with PSW #132, they shared that they were told by the DOC that they were fully staffed, but that was counting the CSAs. They shared that CSAs were scheduled and that calls were not being made to cover those shifts by PSWs.

The licensee failed to ensure that the written staffing plan for the nursing and personal support services programs provided for a staffing mix that was consistent with residents' assessed care and safety needs.

This area of non-compliance was identified during a Complaint Inspection, log #006209-18.

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 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 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.

The MOHLTC received two anonymous complaints stating that residents were not getting their scheduled showers or baths because of staffing shortages in the home.

PSW #124 and #125 were interviewed and shared that they had been short PSWs on the floor and when that happens the bath shifts get a care assignment instead, so the baths do not get done. They said that the home tries to cover the missed shifts by calling staff in or asking staff to extend their shifts.

PSW #123 was interviewed and shared that residents were not always getting their baths as PSWs scheduled for bath shifts had to be given a care assignment because they were short PSWs on the floor.

DOC #101 was interviewed and shared that they have been short PSWs and shared that if residents miss their baths they try to offer them a bed bath or a make-up bath later that day or the next day. They shared that baths were documented in point of care and if a bath/shower was missed or refused the PSW was to report it to the registered staff. Registered staff was then to enter a progress note as to the reason the bath was missed or refused.

A) During this inspection, resident #014 shared that they felt that they did not get their baths twice a week as the home was short of staff at times.

Review of the home’s bath list showed that resident #014 was scheduled to have a bath on two specific days each week. The clinical record review of resident #014’s point of care documentation was completed for a six week period in 2018 and showed they did not get their tub bath on two specific dates during the review period.

The DOC reviewed the bath documentation in point of care and agreed that resident #014 was not bathed on the specific dates in 2018, as there was documentation to support that the resident refused.

B) During this inspection, resident #015 expressed that they were not getting their bath twice weekly.

Review of the home's bath list showed that resident #015 was scheduled to have a bath on two specific days each week. The clinical record was reviewed of resident #015's point of care documentation for a six week period in 2018 and showed they did not get their tub bath on two specific dates during the review period.

DOC #101 reviewed the bath documentation in point of care and agreed that resident #015 was not offered a bed bath on one of the specific dates during the review period in 2018 and was not bathed on the other date.

C) Resident #019 was interviewed and they shared that they sometimes missed their bath because there was not enough staff working.

Review of the home's bath list showed that resident #019 was scheduled to have a bath on two specific days each week. The clinical record review of resident #019's current plan of care stated that resident #019 was to be offered a tub bath; however if they refused they were to be offered a bed bath.

The clinical record was reviewed of resident #019's point of care documentation for a six week period in 2018 and showed they did not get their tub bath on six specific dates during the review period.

DOC #101 reviewed the bath documentation in point of care and agreed that resident #018 was not bathed twice per week.

The licensee failed to ensure that resident #014, #015 and #109, were bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

This area of non-compliance was identified during a Complaint Inspection, log #006209-18.

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

A) Resident #006's plan of care indicated that they had specific nutritional interventions. The plan of care also included the use of a mobility device for positioning during meal times.

During the observation on a specific date in 2018, resident #006 was observed eating at an angle and was observed trying to sit upright.

CSA #143 was interviewed and acknowledged that they did not know resident #006's nutritional interventions and level of risk. The CSA said that if they positioned the resident upright to eat, then they had to stay with them as the resident could fall out of their mobility device.

PSW #111 was interviewed and acknowledged that the resident should be positioned upright to eat safely and their mobility device should be in good working order to assist with seating, but was unsure of the resident's nutritional interventions. They did not know if the resident had any nutritional risks.

B) Resident #012's documented plan of care indicated that they were a high nutritional

risk. The plan of care also included the use of a mobility device and they said the resident should be upright during meal times.

During observation on three specific dates in 2018, resident #012 was observed being fed their meal by PSW #112 and was positioned at an angle.

PSW #112 was interviewed and indicated that the resident was not a nutritional risk. The PSW indicated that the mobility device should be in an upright position for meals.

In an interview with the RD, they acknowledged that the resident was a high nutritional risk and should have been seated upright at a 90 degree angle during the meal.

C) Resident #013's documented plan of care indicated that they were a high nutritional risk. The plan of care also included the use of a mobility device, which was acknowledged by PSW #131 and they said the resident should be positioned upright during meal times.

During the observation on three specific dates in 2018, resident #013 was observed being fed their meal by PSW #133 and was positioned at an angle.

PSW #133 was interviewed and indicated that the resident was not at nutritional risk. The PSW indicated that the mobility device should be in an upright position for meals.

In an interview with the RD, they acknowledged that the resident was a high nutritional risk and should have been seated upright at a 90 degree angle during the meal. Resident #013 was not safely positioned while eating.

The licensee failed to ensure that proper techniques were used to assist resident #006, #012 and #013 with eating, including safe positioning.

This area of non-compliance was identified during a Complaint Inspection, log #005151-18.

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records

Specifically failed to comply with the following:

s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience. O. Reg. 79/10, s. 234 (1).
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession. O. Reg. 79/10, s. 234 (1).
3. Where applicable, the results of the staff member's criminal reference check under subsection 75 (2) of the Act. O. Reg. 79/10, s. 234 (1).
4. Where applicable, the staff member's declarations under subsection 215 (4). O. Reg. 79/10, s. 234 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member: 1. The staff member’s qualifications, previous employment and other relevant experience.

CSA #122, #137 and #140 employee files were reviewed. Review of these employee files revealed that there were no copies of any diplomas or any transcripts from any educational institutions in the files.

CSA #137’s file contained a letter of offer of employment with a specific date in 2018 and signed by DOC#101. When DOC #101 was asked how the CSA qualifications were verified for CSAs #122, #137 and #140, they shared that they did not know and that they would have to check with the Administrator #100.

Administrator #100 shared that they assumed that copies of the qualifications (high school diplomas or other diplomas/certificates) for the CSAs #122, #137 and #140 were done by the front office.

The licensee failed to ensure that a record was kept for CSAs #122, #137 and #140, that included at least the following with respect to a to the staff member: The staff member’s qualifications, previous employment and other relevant experience.

This area of non-compliance was identified during a Complaint Inspection, log #006209-18.

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #8: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the rights of residents are fully respected and promoted in that every resident had the right to be afforded privacy in treatment and in caring for his or her personal needs.

During this inspection resident #014 shared that they referred to themselves as "the inmates". When asked to explain what made them feel that way, they shared that one thing was where they were bathed, as there were two bath tubs in the room and both were used at the same time. They explained that staff sometimes pulled the privacy curtains, but they could also hear everything being done with the other resident and vice versa.

The tub room by resident room #51 was observed. Two therapeutic tubs, a sink and a toilet were noted to be in the tub room. Ceiling lifts were also noted. Privacy curtains were in place; however when drawn between the two tubs there was a gap noted due to the ceiling lift tracking allowing one to see from one tub to another.

PSW #124 and #125 shared that they worked the bath shifts and they do bath two women or two men at the same time. They also shared that they may use the toilet in the tub room if one of the residents required toileting. They said they used the privacy curtains in the room to provide privacy.

DOC #101 was shown the gap in the privacy curtain between the tubs and agreed that would not provide privacy. They agreed that the resident being bathed in one tub or a resident using the toilet would be heard by the resident in the next tub and vice versa.

The licensee failed to ensure that the rights of residents were fully respected and promoted in that every resident had the right to be afforded privacy in treatment and in caring for their personal needs.

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 the rights of residents are fully respected and promoted in that every resident had the right to be afforded privacy in treatment and in caring for their personal needs; and to ensure that resident's were reassessed and the plan of care reviewed and revised at a time the resident's care needs changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #9: 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

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

A) Resident #006 was assessed by the Speech Language Pathologist (SLP) prior to admission to the home for nutritional mechanical problems.

The resident's clinical record was reviewed and the initial nutrition assessment identified the resident was on a specific diet; specific nutritional interventions and the SLP recommended a therapeutic diet.

The Registered Dietitian (RD) developed and implemented the nutrition and hydration plan of care, which included the interventions based on the assessment and the SLP

recommendations.

The resident was observed at meal service on five specific dates and times and the nutritional interventions were not implemented.

The nutrition and hydration plan of care directed staff to offer specific meal choices and specific nutritional interventions.

PSW #111 was interviewed and acknowledged the resident was on a specific diet and had restrictions to their food intake. The PSW was not aware of the nutritional interventions in the resident's nutritional plan of care. The PSW said that the PSWs believed the resident was capable of deciding what they wanted to eat and if the resident chose certain foods or fluids, then they gave the resident what they wanted because it was a quality of life decision.

CSA #143 was interviewed and they were not aware of the resident's dietary needs and/or restrictions. The CSA said they didn't know that the resident had any nutritional mechanical problems.

The RD was interviewed and reviewed the resident's individualized menu, their nutrition and hydration assessment and the interventions on the plan of care for resident #006. The RD acknowledged the resident should be offered two specific choices at lunch and dinner and the nutritional interventions as a result of the resident's medical conditions, as well as the resident's preferences.

B) Resident #006's physician had ordered a specific test to be completed, but it was not completed until eight days later on a specific date in 2018.

The licensee's policy related to the test, directed the registered staff to assign the test to a PSW and to contact the physician/NP, if unable to complete the test.

The clinical record was reviewed, which confirmed the physician's orders for the test and there was no documentation in the progress notes that the physician/NP were notified that there were any issues in completing the test.

RN #114 was interviewed and indicated that they would obtain an order from the physician for the specific test and if they were unable to complete the test within 12 hours, they would call the physician for additional orders.

The DOC #101 was interviewed and acknowledged that staff should complete the test by the next shift, if not, they were expected to contact the physician and obtain further orders. The inspector reviewed the physician's order and when the test was completed with the DOC. The DOC said that this was far too long before the test was completed.

The licensee failed to provide care to resident #006 as specified in their plan of care.

This area of non-compliance was identified during a Complaint Inspection, log #005151-18.

2. The licensee failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the residents' plan of care and had convenient and immediate access to it.

Resident #006's clinical record was reviewed and the nutrition plan of care identified the resident was on a specific diet and nutritional interventions.

CSA #143 was interviewed and they were not aware of the resident's dietary needs and/or restrictions. The CSA said they didn't know the resident's nutritional problems and/or interventions. The CSA said that they do not have access to the plan of care.

The RD was interviewed and acknowledged they reviewed resident #006's nutrition and hydration plan of care with staff and the staff were expected to use the diet list and individualized menu to ensure the resident's needs were met.

PSW #111 acknowledged that the CSA's did not have access to the plan of care and/or the point of care documentation.

The licensee failed to ensure that staff and others who provide direct care to resident #006, were kept aware of the contents of the residents' plan of care and had convenient and immediate access to it.

This area of non-compliance was identified during a Complaint Inspection, log #005151-18.

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 the care set out in the plan of care was provided to the resident as specified in the plan; to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the residents' plan of care and had convenient and immediate access to it, to be implemented voluntarily.

WN #10: 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 failed to ensure that the any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with O. Reg. 79/10, s. 30 (1 & 2), the licensee was required to ensure that the falls prevention program included goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required; and to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #006 was assessed as high risk for falls. The resident had four falls on four

specific dates in 2018.

(i) The clinical record was reviewed and there was no documentation that the Substitute Decision Maker (SDM) was notified when the resident had a fall on a specific date in 2018.

The licensee’s policy titled “Falls Prevention”, directed registered staff to notify the SDM.

The Assistant Director of Care (ADOC)/Falls Lead #109 was interviewed and acknowledged that the registered staff were expected to notify the SDM when the resident falls and as per their falls prevention policy and procedures.

(ii) During the clinical record review, LTCH Inspector #527 was unable to locate the Head Injury Routine (HIR) for the fall the resident had on two specific dates in 2018, and the HIR for two specific dates were incomplete. The registered staff did not conduct the HIR after two specific falls in 2018, when the resident was eating dinner or when they were sleeping.

The licensee’s policy titled “Head Injury Routine”, directed registered staff to complete the HIR as per the schedule outlined on the form and this was not completed.

DOC #101 was interviewed and acknowledged that when the HIR was being performed on residents as a result of a fall, the registered staff were expected to wake residents and/or do the HIR before/after the meal time.

The licensee failed to ensure that the Falls Prevention and Head Injury Routine policies were complied with.

(iii) Resident #006 was transferred to the hospital on a specific date in 2018.

The clinical record was reviewed and there was no documentation that the SDM had completed the advanced directives for resident #006 when they were admitted on a specific date in 2018; there was no progress note that there was any discussion with the SDM related to advance directives and on the checklist the registered staff complete when resident’s move-in to the home, there was no documentation that the advance care plan was obtained.

The SDM was interviewed prior to this inspection and shared their concerns that when

the resident went to the hospital, they were unsure as to what would be done if the resident would have needed cardiopulmonary resuscitation (CPR) while in the hospital, if they needed CPR while living in the home, or would the home send their loved one to the hospital, they weren't sure.

The licensee’s policy titled “Advance Care Planning”, indicated that advance care planning discussions can occur at admission or if the SDM would like an opportunity to discuss directive issues with other family members, etc, then the discussion will occur at the initial care conference. The policy directed staff to document all discussions with the SDM on the resident record as well as on the appropriate planning tool.

The ADOC #109 was interviewed and said they obtain the advance directives signed on admission and if the resident/SDM wants to make a changes, that could occur at any time. The ADOC was unable to locate any documentation related to follow up with the SDM as the advance care planning documentation did not occur at admission and there was no documentation related to what was communicated to the hospital regarding the resident’s advance care planning.

The licensee failed to ensure that the Advance Care Planning policy was complied with.

This area of non-compliance was identified during a Complaint Inspection, log #005151-18.

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 where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may of occurred shall immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident that resulted in harm or a risk of harm to the resident.

The Ministry of Health and Long Term Care received a call reporting neglect of a resident in the home to the management on a specific date in 2017.

DOC #101 shared a letter with a specific date in 2017, which stated that they wanted to make sure they were aware of their complaint of resident abuse and neglect that they reported to their charge nurse.

DOC #101 shared that they did not complete a Critical Incident System (CIS) report as they did not feel it was abuse or neglect. When asked if resident #019 had been interviewed about the incident they said there was no documentation to indicate that the resident was interviewed. DOC #101 also shared that the staff working on a specific shift and date and the charge nurse, to whom the alleged neglect was reported to, and PSW #113 mentioned in the letter were not interviewed.

The clinical record review showed that there were no progress notes or documented assessments of resident #019 completed at the times that the alleged neglect was reported.

Review of the licensee's policy titled "Prevention of Abuse and Neglect of a Resident", directed that all employees, volunteers , agency staff, private duty care givers, contracted service providers, residents, and families were required to immediately report any suspected or known incident of abuse or neglect to the Director of the Ministry of Health and Long Term Care (MOHLTC) and the Executive Director / Administrator or designate in charge of the home.

The Executive Director / Administrator or designate initiated the investigation by requesting that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the event, reiterating anonymity and protection against retaliation.

Administrator #100 was interviewed and shared that a CIS was not submitted to the Director.

The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may of occurred shall immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident that resulted in harm or a risk of harm to the resident.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

An anonymous complaint was received by the MOHLTC regarding residents being woke up for care during a specific shift.

A) The clinical record review revealed that resident #006 was admitted in 2018 and on admission a Sienna Initial Assessment-V3 was done. Section 4 of the assessment was titled Customary Routines and indicated that resident #006 liked to get up at and to go to bed at specific times. Review of resident #006's written plan of care and kardex did not include resident #006's bed time preferences.

During an interview with PSW #124, they shared that there was a list of primary care assignments for residents that were assigned to the PSWs that work specific shifts. PSW #124 shared the list. Resident #006 was assigned to the PSW on this specific shift. PSW

#124 shared that resident #006 was usually awake and crawling out of bed at certain times. When asked where they would find out what time a resident liked to get up in the morning or to go to bed at night, PSW #124 said that it was not written anywhere in the written plan of care or kardex. PSW #124 said that resident #006 could not tell them what time they liked to get up or to go to bed.

During an interview with PSW #148, they shared that resident #006 was assigned to the PSW on a specific shift and that meant that they would be responsible for their primary care. They shared that would include personal care and dressing of the resident, but not necessarily getting them out of bed. PSW #148 said that resident #006 was usually awake and crawling out of bed at certain times.

Review of resident #006's progress notes over a three month period in 2018 was completed and there was no documentation that resident #006 was noted to be crawling out of bed. Review of resident #006's point of care documentation showed that during a three week period in a specific month in 2018, resident #006's personal care and dressing was documented during a specific time period, which did not align with the resident's preferences.

During an interview with the DOC #101, they shared that for newer admissions the home completed the Sienna Initial Assessment V3 that included sleep and rest time preferences. They shared that the information was then used to create the plan of care and care plan for the resident. DOC #101 shared that they had discussions with staff as to what residents were awake and could be assigned to night care. DOC #101 shared that resident #006's desired bed time and rest routines were not included in their written plan of care.

The licensee failed to ensure that each resident of the home had their desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

B) The clinical record was reviewed for resident #017 and the current written plan of care revealed resident #017's sleep pattern.

During an interview with PSW #148 they shared that resident #017 was assigned to the PSW on the specific shift and that meant that they would be responsible for their primary care. They shared that would include personal care and dressing of the resident, but not necessarily getting them out of bed. PSW #148 said that resident #017 had their personal care and dressing done by the this specific PSW, but were transferred out of

bed to their chair by the other PSWs working the next shift.

Review of resident #017’s point of care documentation showed that during a six week period in 2018, resident #017’s personal care and dressing was documented during a specific time.

Resident #017 shared that staff came in during a specific time to get them out of bed. They shared that they liked to get up about at a specific time.

The licensee failed to ensure that each resident of the home, specifically residents #006 and #017, had their desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

This area of non-compliance was identified during a Complaint Inspection, log #006209-18.

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 has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee failed to ensure that every resident received end-of-life care when required in a manner that met their needs.

Resident #008 was ordered specific medication by the physician. The resident's health condition declined and the SDM changed the resident's advanced care directives.

The clinical record was reviewed and it revealed that the resident #008's health condition deteriorated and the SDM was notified by registered staff that if the resident went into distress that they could administer specific medication. At a specific time of day, the SDM requested the registered staff to administer the medication to the resident and was told by the nurse that they couldn't, but the Nurse Practitioner (NP) could and they were in a meeting at the time. The nurse spoke to the RPN approximately an hour later; however the NP left the home without administering the medication to resident #008. Subsequently, the RPN informed the SDM that they tried to contact the NP with no success.

Later in the evening on the same date, the physician on call was contacted and an order for the medication administration was received. The resident was not administered their first dose of the medication until several hours later. The medication was ineffective and it was not until the fourth dose, that the medication was effective.

According to the licensee's protocol titled "End of Life", identified that residents shall be provided end of life care in the last days and hours of their life from a multidisciplinary team to enhance decision making in the provision of individualized care and enable the resident and their family choices of the best possible options to maximize the resident's quality of life while dying.

DOC #101 was interviewed and an internal investigation revealed there was a breakdown in communication as the RPN did not speak to the NP at the home as they discussed with family and attempted to notify the NP by telephone after they left the home. It was not an expectation that the NP be on call to the home. The physician on call was contacted and an order was received for medication. The DOC acknowledged that resident #008's care needs changed in relation to medication management.

As per the SDM and the nursing documentation, the delay in medication management implemented did not meet the resident's end of life needs.

The licensee failed to ensure that resident #008 received end-of-life care when required in a manner that met their needs.

This area of non-compliance was identified during a Complaint Inspection, log #014536-17.

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 every resident received end-of-life care when required in a manner that met their needs, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #008's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for assessing pain.

A clinical record review was completed for resident #008. The resident had a significant decline in overall health and on a specific date in 2017, the advanced care directives were changed. The written plan of care was not revised when the resident's care needs changed. There were no pain assessments completed on the specific date when the resident was experiencing ineffective and end of life medication management.

The licensee's policy titled "Pain and Symptom management", stated residents would be cared for in a manner that supports their quality of living; validating their voice, choice and goals of care for pain and symptom management. Registered staff would make referrals as appropriate to other multidisciplinary team members and consider initiating a pain study tool for 24 hours or longer to assist with the assessment and evaluation of pain management when pain remained regardless of interventions.

According to the licensee's protocol titled "End of Life", identified that residents shall be provided end of life care in the last days and hours of their life from a multidisciplinary team to enhance decision making in the provision of individualized care and enable the resident and their family choices of the best possible options to maximize the resident's quality of life while dying.

The resident did not have any pain assessments documented and the plan of care was not reviewed.

The licensee failed to ensure when resident #008's medication management was ineffective after the initial interventions were implemented, that the resident was assessed using a clinically appropriate assessment instrument specifically designed for assessing pain.

This area of non-compliance was identified during a Complaint Inspection, log #014536-17.

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 when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident’s sleep patterns and preferences for the resident.

An anonymous complaint was received regarding residents being woke up for care during a specific shift.

The clinical record review revealed that resident #018 napped during specific times, otherwise slept well.

PSW #124 shared that resident #18 had their personal care and dressing done at a specific time and were left in bed for the next shift to get them up. PSW #124 shared that resident #018’s written plan of care and kardex did not include their bed time preferences as to when they preferred to go to bed or to get up.

Review of resident #018’s point of care documentation showed that during a six week period in 2018, resident #018’s personal care and dressing was provided during a specific time.

During an interview with the DOC#101, they shared that the resident’s sleep preferences as far as their preferred time to get up or to go to bed were not identified in the plan of care and that they should have been. They shared that for newer admissions the home completed the Sienna Initial Assessment V3 that included sleep and rest time preferences, but that assessment was not available when resident #018 was admitted.

The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident’s sleep patterns and preferences for the resident.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A) The 2017 annual program evaluation for Nutrition and Hydration was reviewed and the written record included the summary of changes made; however the date that those changes were implemented were not documented in the written record.

B) The 2017 annual program evaluation for Falls Prevention was reviewed and the written record included the summary of changes made; however the date that those changes were implemented were not documented in the written record.

The DOC was interviewed and acknowledged that the date(s) their changes and accomplishments were implemented for each of the programs noted above, were not documented in the 2017 annual program evaluation.

The licensee failed to ensure that the written record of the 2017 annual program evaluation for the Nutrition and Hydration and the Falls Prevention program included the date that the changes and improvements were implemented.

This area of non-compliance was identified during a Complaint Inspection, log #005151-18.

Issued on this 14th day of September, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : KATHLEEN MILLAR (527), AMANDA COULTER (694), SHARON PERRY (155)

Inspection No. / No de l'inspection : 2018_742527_0012

Log No. / No de registre : 034855-16, 008479-17, 014536-17, 015149-17, 029751-17, 005151-18, 006209-18, 011523-18

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Aug 29, 2018

Licensee / Titulaire de permis : 2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8

LTC Home / Foyer de SLD : Creedan Valley Care Community
143 Mary Street, CREEMORE, ON, L0M-1G0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Paula Rentner

To 2063412 Ontario Limited as General Partner of 2063412 Investment LP, 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:

a) Ensure that at least one registered nurse who was 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.

Grounds / Motifs :

1. The licensee 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 of the home was on duty and present in the home at all times, except as provided for in the regulations.

An anonymous complaint was received stating that the home had no Registered Nurse (RN) in the home on two specific dates in 2017. Another complaint was received stating that on a specific date in 2017, the home was scheduling agency Registered Nurses (RN) to work a specific shift.

A review of the registered staff schedules was completed, which included approximately a six month period from 2017 to 2018. The review showed that agency RNs worked numerous shifts during the six month period.

The schedules reviewed from 2017 to 2018, also showed that there was no RN on duty and present in the home on a specific date and time in 2017. The shift

was worked by a Registered Practical Nurse (RPN).

During an interview with the Director of Care (DOC) #101, they shared that they used agency staff and that they were currently recruiting for a part time RN position. They shared the goal was to limit the use of agency RNs. A review of RN schedules was completed with the DOC #101. The DOC#101 shared that during specific shifts there were no RPNs working.

Review of the home's annual staffing plan evaluation for 2017, identified a goal to decrease agency usage within the home.

The licensee 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 of the home was on duty and present in the home at all times, except as provided for in the regulations.

This area of non-compliance was identified during a Complaint Inspection, log #029751-17.

The licensee 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 of the home was on duty and present in the home at all times, except as provided for in the regulations.

The severity of this issue was determined to be a level 2 as there was potential for harm to residents. The scope of the issue was a level 2 as there was a pattern. The home had a level 3 as there was one or more related non-compliance in the last 36 month. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 17, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee must be compliant with s.15 (2) (a) of the LTCHA.

Specifically the licensee must:

a) Ensure residents #006, #010 and #016, and any other resident, have their mobility devices kept clean and sanitary.

b) Ensure there is a schedule to clean residents #006, #010 and #016's mobility devices and there is documentation maintained of the mobility devices being cleaned.

Grounds / Motifs :

1. The licensee failed to ensure that the residents' equipment were kept clean and sanitary.
Resident #006's, #010's, and #016's mobility equipment was observed during this inspection as being soiled. The residents' equipment remained soiled throughout the inspection.

The licensee's policy titled "Equipment Maintenance and Cleaning - Nursing and Resident Care", did not include a schedule for cleaning of specific resident equipment.

(i) Resident #006's equipment was observed during the course of this inspection

and it was soiled. The schedule for the resident's equipment cleaning could not be located. Review of the resident's clinical record identified no task for cleaning for this resident's equipment during specific months in 2018.

(ii) Resident #010's equipment was observed soiled throughout the inspection. Review of the resident's clinical record identified a task for equipment cleaning for this resident. The Point of Care (POC) notes were reviewed for a three month period during 2018, which identified the resident's equipment was cleaned three times.

(iii) Resident #016's equipment was observed during the course of the inspection and it remained soiled. Review of the resident's clinical record identified a task for equipment cleaning for this resident. The POC notes were reviewed for a three month period in 2018, there was no documentation that the equipment was cleaned.

The DOC was interviewed and acknowledged that they were not able to locate resident #006's equipment cleaning schedule. The DOC also acknowledged that resident #010 and #016, were scheduled for their equipment cleaning each week. The DOC indicated that it was an expectation that PSW staff on a specific shift were to clean residents' equipment once a week according to the schedule in POC and this did not occur.

The licensee failed to ensure that the residents #006, #010 and #016 had their equipment, kept clean and sanitary.

The severity of this issue was determined to be a level as there was minimal risk to residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 2 history of one or more unrelated non-compliance in the last 36 months.
(527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee must be compliant with s.76 (2) of the LTCHA.

Specifically the licensee must:

a) Ensure that agency Registered Nurse (RN) #153, #154, #155, #156, #157, #158; #159; and agency Registered Practical Nurse (RPN) #103, #160, #161 and #162, as well as any other agency staff and all other staff at the home, do not perform their responsibilities before receiving training in the following areas:

1. The Residents' Bill of Rights;
2. The long-term care home's mission statement;
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
4. The duty under section 24 to make mandatory reports;
5. The protections afforded by section 26;
6. The long-term care home's policy to minimize the restraining of residents;
7. Fire prevention and safety;
8. Emergency and evacuation procedures;
9. Infection prevention and control;
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities; and
11. Any other areas provided for in the regulations.

b) The training will be documented and the training records, for agency RN #153, #154, #155, #156, #157, #158; #159; and agency RPN #103, #160, #161 and #162, as well as any other agency staff and all other staff at the home, will be kept in the home.

Grounds / Motifs :

1. The licensee failed to ensure that all staff at the home had received training before performing their responsibilities as required by this section.

A review of the home's staff schedules and Vacant Hours Reports showed that the home used agency RNs, RPNs and PSWs.

A review of the Registered Staff schedules was completed for a seven month period in 2017 and 2018. The review showed that agency RNs #151, #152, #153, #154, #155, #156, #157, #158 and #159, worked during the seven month period between 2017 and 2018. The review showed that agency RPNs #103,

#147, #160, #161 and #162, also worked during this time.

A review of the Vacant Hours Reports for a three month period in 2018 showed that agency PSWs worked a specific number of hours during this period.

The DOC #101 was interviewed and shared that during the three month period in 2018, agency RNs worked a specific number of hours and agency RPNs worked a specific number of hours. They shared that agency staff received orientation and that the Administrative Manager was the designated lead for the training and orientation program.

The Administrative Manager #149 was interviewed and shared the agency education records. Review of these records was completed and showed that in 2017, agency staff were offered to review the following:

• Prevention of Abuse and Neglect of a Resident Policy, revised January 2015;
• Vision, Mission and Values;
• Employee conduct Policy, revised March 2015;
• Accessibility for Ontarian's with Disabilities Act Policy, revised November 2017;
• Confidentiality Agreement;
• Zero Lift Protocol and Statement of Understanding;
• The Chain of Disease Transmission Policy, revised May 2016; and
• The Residents' Bill of Rights.

Review showed that agency RN #153, #154, #155, #156, #157, #158 and #159 had not completed any of the above education. Review showed that agency RPN #103, #160, #161 and #162 had not completed any of the above education.

The Administrative Manager #149 said that if they know that an agency staff were coming in to work they have them come and review the documents, but often agency come in for specific shifts and they did not review the documents.

DOC #101 provided one additional file that was for agency RN #152. Agency RN #152, had no documented evidence that the Residents' Bill of Rights, the licensee's policy to minimize the restraining of residents, fire prevention and safety, emergency and evacuation procedures, infection prevention and control and medication management system orientation had been provided.

During an interview with agency RPN #147, they shared that they had not received any education on fire prevention and safety, or emergency and evacuation procedures.

DOC #101 had no records to support that any agency staff had received fire prevention and safety, or emergency and evacuation procedure training before performing their responsibilities.

The licensee failed to ensure that all staff at the home had received training before performing their responsibilities as required by this section.

The severity of this issue was determined to be a level 2 as there was potential for harm to residents. The scope of the issue was a level 3 as it related to all agency staff and home training information reviewed. The home had a level 2 history of one or more unrelated non-compliance in the last 36 months. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 2018

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee must be compliant with s.31 (3) (a) of the LTCHA.

Specifically the licensee must:

a) Ensure that the written staffing plan for the nursing and personal support services programs provide for a staffing mix that is consistent with residents' assessed care and safety needs.

Grounds / Motifs :

1. The licensee failed to ensure that the written staffing plan for the nursing and personal support services programs provided for a staffing mix that was consistent with residents' assessed care and safety needs.

During this inspection, PSWs #113, #118, #123, #124, #125 and #132, all shared that they often had to work short, the staff scheduled to do the bathing shifts were being reassigned to the floor to provide primary care, thus resulting in residents not receiving their baths, and CSAs had been hired to help; however

they were not able to provide any personal care or see any residents unless they were dressed.

During this inspection, CSAs #122, #136 and #137 shared that they were hired to assist the PSWs. They shared that their duties included making beds, emptying laundry and garbage, serving and feeding meals to residents, serving and assisting residents with nourishment cart, being a second person in a two-person transfer, portering residents to meals and activities. They all shared that they did not provide any personal care of bathing, toileting, or dressing, as they were not allowed to see any residents that were not dressed. They shared that they had no access to Point of Care, so could not do any documentation of food or fluids they had given to residents nor could they see the resident care plans or kardex.

During an interview with Administrator #100, they shared that they had hired eight CSAs, that started on a specific date in 2018. They shared that they were hired as the home was experiencing a shortage of PSWs.

During this inspection, record review showed that resident #014, #015 and #019 had not been bathed, at a minimum, twice a week by the method of their choice, including tub baths, showers, and full body sponge baths.

During this inspection, resident #005 also expressed concerns that they were not always getting their showers as the home was short of staff. They shared that they did not get their shower on a specific date in 2018. Resident #021, also expressed that they had missed getting baths and that they did not get their bath on a specific date in 2018. Record review showed that there was no documentation in point of care showing that resident #005 and #021, was provided with their shower or bath on the specific dates they identified in 2018.

Review of point of care documentation showed that residents #016, #023, #024, #025, #026, #027, #028, #029, #030 and #031, did not receive their bath or shower. DOC #101 shared that the staff working the bathing shifts were reassigned to work on the floor on a specific date in 2018.

Review of the home's staffing plan compliment for a 24 hour period for PSWs was completed and a review of the Vacant Hours Reports for a three month period in 2018, was completed and identified there was vacant PSW hours during the three month period.

It was noted that as of a specific date in 2018 and each report after that date included the CSA hours; therefore making the total vacant PSW hours not a true reflection of total vacant PSW hours.

During an interview with DOC #101, they shared that they allow CSAs to work on two specific shifts to a maximum of two CSAs on each of those shifts. They shared that if they could not schedule the full complement of PSWs on specific shifts, they would also schedule two CSAs. They shared that they do not call for agency PSWs unless they were more than two PSWs short on each shift.

During an interview with PSW #123, they shared that they were told that they were fully staffed; however that was only if the CSAs were counted as part of the PSW staff.

During an interview with PSW #132, they shared that they were told by the DOC that they were fully staffed, but that was counting the CSAs. They shared that CSAs were scheduled and that calls were not being made to cover those shifts by PSWs.

The licensee failed to ensure that the written staffing plan for the nursing and personal support services programs provided for a staffing mix that was consistent with residents' assessed care and safety needs.

This area of non-compliance was identified during a Complaint Inspection, log #006209-18.

The severity of this issue was determined to be a level 2 as there was minimal harm to residents. The scope of the issue was a level 2 as there was a pattern based on 5 residents reviewed. The home had a level 2 history of one or more unrelated non-compliance in the last 36 months.

(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 2018

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with s.33 (1) of the LTCHA.

Specifically the licensee must:

a) Ensure residents #014, #015, and #019 have been bathed, at a minimum, twice a week by the method of their choice and that it is documented in point of care.

Grounds / Motifs :

1. The licensee 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) During this inspection, resident #014 shared that they felt that they did not get their baths twice a week as the home was short of staff at times.

Review of the home's bath list showed that resident #014 was scheduled to have a bath on two specific days each week. The clinical record review of resident #014's point of care documentation was completed for a six week period in 2018 and showed they did not get their tub bath on two specific dates during the review period.

The DOC reviewed the bath documentation in point of care and agreed that resident #014 was not bathed on the specific dates in 2018, as there was

documentation to support that the resident refused.

B) During this inspection, resident #015 expressed concerns that they were not getting their bath twice weekly. Resident #015 said they had specific bath days and they never refuse their tub bath.

Review of the home's bath list showed that resident #015 was scheduled to have a bath on two specific days each week. The clinical record was reviewed of resident #015's point of care documentation for a six week period in 2018 and showed they did not get their tub bath on two specific dates during the review period.

DOC #101 reviewed the bath documentation in point of care and agreed that resident #015 was not offered a bed bath on one of the specific dates during the review period in 2018 and was not bathed on the other date.

C) Resident #019 was interviewed and they shared that they sometimes missed their bath because there was not enough staff working.

Review of the home's bath list showed that resident #019 was scheduled to have a bath on two specific days each week. The clinical record review of resident #019's current plan of care stated that resident #019 was to be offered a tub bath; however if they refused they were to be offered a bed bath.

The clinical record was reviewed of resident #019's point of care documentation for a six week period in 2018 and showed they did not get their tub bath on six specific dates during the review period.

DOC #101 reviewed the bath documentation in point of care and agreed that resident #018 was not bathed twice per week.

The licensee failed to ensure that resident #014, #015 and #109, were bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

This area of non-compliance was identified during a Complaint Inspection, log #006209-18.

The severity of this issue was determined to be a level 2 as there was minimal harm to residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 2 history of one or more unrelated non-compliance in the last 36 months.
(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 2018

Order # / Ordre no : 006 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with s.73 (1) 10 of the LTCHA.

Specifically the licensee must:

a) Ensure residents #006, #012 and #013, and any other resident, that is a high nutritional risk, is be positioned safely when eating or drinking.

Grounds / Motifs :

1. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

A) Resident #006's plan of care indicated that they had specific nutritional interventions. The plan of care also included the use of a mobility device for positioning, which was to be upright during meal times.

During the observation on a specific date in 2018, resident #006 was observed eating at an angle and trying to sit upright.

CSA #143 was interviewed and acknowledged that they did not know resident #006's nutritional interventions and level of risk. The CSA said that if they positioned the resident upright to eat, then they had to stay with them as the resident could fall out of their mobility device.

PSW #111 was interviewed and acknowledged that the resident should be positioned upright to eat safely and their mobility device should be in good working order to assist with seating, but was unsure of the resident's nutritional interventions. They did not know if the resident had any nutritional risks.

B) Resident #012's documented plan of care indicated that they were a high nutritional risk. The plan of care also included the use of a mobility device, which was acknowledged by PSW #131 and they said the resident should be upright during meal times.

During observation on three specific dates in 2018, resident #012 was observed being fed their meal by PSW #112 and was positioned at an angle.

PSW #112 was interviewed and indicated that the resident was not a nutritional risk. The PSW indicated that the mobility device should be in an upright position

for meals.

In an interview with the RD, they acknowledged that the resident was a high nutritional risk and should have been seated upright at an angle during the meal.

C) Resident #013's documented plan of care indicated that they were a high nutritional risk. The plan of care also included the use of a mobility device, which was acknowledged by PSW #131 and they said the resident should be positioned upright during meal times.

During the observation on three specific dates in 2018, resident #013 was observed being fed their meal by PSW #133 and was positioned at an angle.

PSW #133 was interviewed and indicated that the resident was not at nutritional risk. The PSW indicated that the mobility device should be in an upright position for meals.

In an interview with the RD, they acknowledged that the resident was a high nutritional risk and should have been seated upright at during the meal. Resident #013 was not safely positioned while eating.

The licensee failed to ensure that proper techniques were used to assist resident #006, #012 and #013 with eating, including safe positioning.

This area of non-compliance was identified during a Complaint Inspection, log #005151-18.

The severity of this issue was determined to be a level 2 as there was potential forl harm to residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 3 history as there was 1 or more related non-compliance with this section of the Act.

(527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 2018

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience.
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.
3. Where applicable, the results of the staff member's criminal reference check under subsection 75 (2) of the Act.
4. Where applicable, the staff member's declarations under subsection 215 (4).
O. Reg. 79/10, s. 234 (1).

Order / Ordre :

The licensee must be compliant with s.234 (1) 1 of the LTCHA.

Specifically the licensee must:

a) Ensure that a record is kept for CSA #122, #137 and #140, which includes the staff member's qualifications, previous employment and other relevant experience.

Grounds / Motifs :

1. The licensee failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member: 1. The staff member's qualifications, previous employment and other relevant experience.

CSA #122, #137 and #140 employee files were reviewed. Review of these employee files revealed that there were no copies of any diplomas or any transcripts from any educational institutions in the files.

CSA #137's file contained a letter of offer of employment with a specific date in 2018 and signed by DOC#101. When DOC #101 was asked how the CSA qualifications were verified for CSAs #122, #137 and #140, they shared that they did not know and that they would have to check with the Administrator #100.

Administrator #100 shared that they assumed that copies of the qualifications (high school diplomas or other diplomas/certificates) for the CSAs #122, #137 and #140 were done by the front office.

The licensee failed to ensure that a record was kept for CSAs #122, #137 and #140, that included at least the following with respect to a to the staff member: The staff member's qualifications, previous employment and other relevant experience.

This area of non-compliance was identified during a Complaint Inspection, log #006209-18.

The severity of this issue was determined to be a level 1 as there was minimum risk to residents. The scope of the issue was a level 3 as it related to three of three CSAs reviewed. The home had a level 2 history of one or more unrelated non-compliance in the last 36 months. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 2018

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

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

Issued on this 29th day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Kathleen Millar

Service Area Office / Bureau régional de services : Central West Service Area Office