Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 11, 2019	2018_601532_0026	028524-16, 032386-16, 002526-17, 004508-17, 016792-17, 020872-17, 025272-17, 029666-17, 006077-18, 006626-18, 008193-18, 008970-18, 009164-18, 011457-18, 018328-18, 018565-18, 021726-18	Complaint

Licensee/Titulaire de permis

CVH (No. 2) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Maitland Manor
290 South Street GODERICH ON N7A 4G6

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

NUZHAT UDDIN (532), JANETM EVANS (659)

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): December 3, 4, 5, 6, 7, 10, 11, 12, 14, 17 and 18, 2018.

The following Complaints and Critical Incidents (CIs) were conducted in conjunction with this inspection.
Log #032386-16, CI #0965-00015-16 related to alleged abuse.
Log #002526-17, CI #0965-000004-17 related to alleged abuse.
Log #004508-17, CI #0965-000007-17 related to a fracture.
Log #016792-17, CI #0965-000017-17 related to fall prevention.
Log #025272-17, CI #0965-000021-17, related to a fracture.
Log #029666-17, CI #0965-000024-17, related to fall prevention.
Log # 006626-18, CI #0965-000009-18, related to fall prevention.
Log #011457-18, CI #0965-000010-18, related to alleged abuse.
Log #018328-18, CI #0965-000012-18, related to fall prevention.
Log #018565-18, CI #IL-58303-AH/ 0965-000013-18, related to alleged abuse.
Log #021726-18, CI #0965-000015-18, related to fall prevention.
Log #009164-18, IL-56804-CW, related to availability of supplies, nursing and personal support services and food production.
Log # 008970-18, IL-56757-CW, related to availability of supplies and sufficient staffing.
Log # 008193-18, IL-56576-CW related to sufficient staffing.
Log #006077-18, IL-56200-CW/IL-56545-CW, related to a fall prevention, abuse, continence, medication and plan of care.
Log #020872-17, IL-52652-LO related to sufficient staffing.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED) Director of Care (DOC), Corporate Consultant, Office Manager (OM), Dietician, Environmental Service Manager (ESM) Recreation and Program Services Manager (RPSM), Physiotherapist, Resident Assessment Instrument (RAI) Coordinators, Ward Clerk, Behaviour Support Ontario Staff (BSO), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Staffing Clerk, Hairdresser, Dietary Aide, Housekeeping staff, Family and Resident Council Representatives, residents and family members.

The inspectors also toured resident home areas and common areas, medication room, kitchen, servery, spa rooms, observed resident care provision, resident staff interaction, dinning services, medication administration, reviewed relevant residents' clinical records, posting of required information, relevant policies and

procedures, as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement.

A complaint was received by the Ministry of Health and Long Term Care (MOHLTC) which alleged a shortage of staff and stated that at times there was no Registered Nurse (RN) in the building.

Review of staff schedules over 25 weeks, showed 12 RN shifts out of a possible 374 shifts (or three per cent) that were filled by either agency staff or one of the home's Registered Practical Nurses (RPNs) working the shift.

Maitland Manor Nursing and PSW Staffing Services Quality Program Evaluation for staffing (2017) documented that there were over six shifts where there was no RN in the home and the home's bed size exceeded 64 beds.

The Ward Clerk stated RNs worked 12 hour shifts. There was one RN on days and one on night shift. They stated that there were times when they were unable to fill vacant RN shifts and the home would try to cover the shift using an agency RN or have one of the home's RPNs work the shift with an RN on call as back up.

The DOC acknowledged the use of agency staff or the home's RPNs to cover RN shift vacancies.

The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement. [s. 8. (3)]

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purpose of the ACT and this Regulation (O.Reg. 79/10, s. 5.) neglect is defined as the failure to provide residents with the treatment, care services or assistance required for health, safety or well-being, and includes inaction or pattern of inaction that jeopardizes the health, safety or well- being of one or more residents.

For the purposes of the definition of "abuse" in subsection 2(1) of the Act,

Verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature, or any form of verbal communication of a belittling or degrading nature, which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Financial abuse is defined as any misappropriation or misuse of a resident's money or property.

a) A Critical Incident submitted to MOHLTC alleged neglect of an identified resident.

Review of the clinical record for an identified resident showed that the resident required assistance with activities of daily living, however, they were left unattended for a prolonged period of time. The resident sustained injures related to this incident.

The DOC acknowledged that the identified resident had been left unattended for a prolonged period of time and stated that staff had not gone back to check on the resident.

b) A Critical incident submitted to the MOHLTC, stated that an identified resident sustained a fall with injury while using a personal assistive device. The RPN who arrived

at the scene observed the resident on the floor and told the PSWs to get the Registered Nurse (RN) as they were going on break.

The RPN acknowledged that they did not assess the resident before going on break and left them on the floor waiting for another registered staff.

c) A complaint was submitted to the MOHLTC which reported that an identified resident had altered skin integrity before they were assessed at the hospital and diagnosed.

A clinical record note indicated that the identified resident had altered skin integrity. However, there was no documentation or assessment of the altered skin integrity for specified period of time after the initial assessment was done. The POA for the resident complained about the altered skin integrity.

The resident was assessed in the Emergency department and a diagnosis was made.

The Director of Care (DOC) acknowledged that there was a gap from the time the altered skin integrity was noted to the time the resident was assessed at the hospital. The DOC said that staff did not take action in terms of addressing the skin issue.

d) A CI reported that an identified resident initiated their call bell and it was not answered for a while.

Clinical records noted that an RN heard loud talking coming from the identified resident's room. When they entered the room, they found a staff member being verbally abusive towards the resident. The resident was observed to be emotionally upset by the incident.

A review of the home's internal investigation records showed the home considered the incident to be abuse and disciplinary measures were taken.

e) This inspection was done based on a CI related to financial abuse.

The CI report stated that an identified resident made care providers aware that they had received money and asked them to take it to the business office for deposit into their trust account. At that time, the office was closed so staff gave the money to an RPN to secure within the home until it could be deposited through the office manager. The RPN did not secure the money in the home, but took the money with them. The office manager made several attempts to remind the RPN to provide the money, but, was unsuccessful. Six

weeks later the office manager made the Administrator aware of the incident. The Administrator and the DOC met with the RPN who said they had forgotten to return the money.

The DOC acknowledged that an RPN had taken the resident's money with them and several attempts were made to ask them to bring the money back but it was not returned for six weeks.

The licensee has failed to ensure that residents are protected from abuse by staff in the home and free from neglect by the licensee or staff in the home. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 has failed to ensure that the staffing plan provided for a staffing mix that was consistent with resident's assessed care and safety needs.

Four complaints were received by the MOHLTC over an eight month period, which alleged a shortage of staff and that residents were not being bathed, assistance with feeding residents was not timely and meals were cold, bed linens or resident's clothing were not being changed.

The staffing plan directed staff: If working more than two PSW's short, both bath aides were pulled and would fill in for that area. Staff were encouraged if they had time to complete baths for their section.

A memo related to working short, from the Director of Care stated that "as a team you were to decide who gets bathed when the bath nurse was on her half bath shift routine".

The home's policy related to Assignment of Resident Care, stated that the Director of Care would establish a system for reviewing the care requirements for residents in the home and assigning staff to provide the required care on a 24 hour basis. The procedure included that the nurse would assign unit staff to provide the required care to each resident on the unit and there would be a reassignment of residents if they were working short.

The Ward Clerk stated that PSWs worked eight hour shifts. There should be 10 scheduled to work on day shift, nine on evening shift and four on night shift. The Ward Clerk said when the census was up for the home they tried to fill shifts and offered overtime as needed for call ins. The Ward Clerk stated that there were six part time lines on day shift, two on evening shift and one on night shift that were vacant.

Review of the PSW schedule for August 2017 showed 31 out of 93 shifts (33 per cent) there was a shortage of PSW staff. Seven of these shifts (eight per cent) they were short two and half PSWs or more.

Review of the PSW schedules for a 21 week period from March 19, 2018 to November 30, 2018 showed a shortage of PSW staff on 212 out of 435 shifts (49 per cent). Thirty four of these shifts (16 per cent) were short by two and a half PSWs staff or greater.

Review of flow sheets for random residents related to bathing for August 2017 showed: An identified resident received three of eight baths. On five of the days the resident was

to receive a bath the home was short PSWs.
An identified resident received six of eight baths. On one of the two days the resident was scheduled to have a bath the home was short PSWs.
An identified resident received six of eight scheduled baths. The resident's bath schedule had been altered to allow the six of eight baths to be administered. On four of scheduled bath days the home was short PSWs.

Review of flow sheets for October to November 2018 showed:
An identified resident received six of eight baths. On two of the days the resident missed a bath, the home was short PSWs.
An identified resident received seven of eight scheduled baths for November 2018. On the day the resident missed a bath, the home was short PSWs.
An identified resident received six of eight scheduled baths in October. On the days the resident missed baths, the home was short PSWs.

The plan of care for each of the above resident's indicated the resident was to receive two baths per week.

In interviews with the identified residents they said that they had missed some of their baths.

PSWs said that usually eight to nine baths were completed on each wing on day shift and there were also baths completed on evening shift. If they were working short of PSWs, they would be pulled from the bath shift to work the unit. When they worked short, residents may not receive their baths. They documented baths on a hard copy flow sheet. The home did not track missed baths; if they were not able to make up the resident's bath, the bath would just be skipped until the next scheduled bath time. They said some residents would express concern about missed baths. A PSW said the home used to call in someone to help make up baths or to cover a shift if PSWs were working short but they no longer did this. A PSW stated the home may try to call staff in to work but there was no one to fill the shift, when it got to the end of a week they would pick and choose which residents to bathe based on who really needed the bath.

The DOC acknowledged a shortage of PSW staff and confirmed intermittent use of agency staff to try to fill the vacant shifts. The DOC acknowledged that when PSWs worked short, residents may be impacted by not having their baths completed, not receiving a bath of their preference, bed linen not being changed or residents may not be dressed in street clothing.

The licensee had failed to ensure that the staffing plan provided for a staffing mix that was consistent with resident's assessed care and safety needs related to bathing. [s. 31. (3)]

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. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not charged for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a Local Health Integration Network.

Observations of continence supplies showed sufficient supplies with a range of products available from liners and pads to various sizes of briefs but not including pull-ups.

The resident profile worksheet indicated which incontinence product residents wore. There were eleven residents identified as using family supplied pull-ups.

The Office Manager stated that they had never billed residents for continence products but products may be ordered through the pharmacy on occasion and then pharmacy would do the billing for this.

The DOC acknowledged if a resident was admitted who used pull ups they were not always offered alternative products from the homes continence supplies to use and that families supplied and paid for pull ups for residents who used pull ups.

The licensee had failed to ensure that residents were not charged for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a Local Health Integration Network. [s. 245. 3.]

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 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).

Findings/Faits saillants :

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

This inspection was completed related to a complaint submitted to the MOHLTC which reported that an identified resident used an assistive device which was not properly applied. The resident was supposed to receive the assistive device but the complainant identified issues with the resident not being properly assessed.

Record review showed that there was no documentation related to the initiation of the assistive device.

Observations were conducted of other identified residents and it showed that the care set out in the plan of care was not provided to the resident.

A PSW confirmed that the assistive device was not applied properly as per care plan.

The DOC acknowledged that the care was not provided to residents as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with O. Reg. 79/10, r. 49 (1), the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, staff did not comply with the licensee's policy Falls Prevention and Management Procedure for head injury routine and procedure for notifying family/POA. The home's Falls Prevention and Management Program Procedure indicated that if a resident hits their head or was suspected of hitting their head (e.g. unwitnessed fall), then their neuro-vitals were to be assessed and documented every hour for four hours then every eight hours for 72 hours.

The home's Falls Prevention and Management Program Policy also indicated that if a resident had fallen, then their family/SDM was to be notified promptly.

a) This inspection was completed related to a complaint submitted to the MOHLTC which reported concerns related to an identified resident's falls.

A review of clinical record showed that the resident was at risk for falls. The records showed that the resident did not have their assessment done according to the home's procedure after they had sustained an unwitnessed fall on specified dates.

A review of clinical records for the resident also showed that the resident's family/SDM was not notified after they had a fall.

b) Review of clinical records for another identified resident showed that the resident was at risk for falls. The records showed the resident did not have their assessment done according to the home's procedure after they had sustained an unwitnessed fall on a specified date.

c) A review of clinical records for an identified resident showed the resident was at risk for falls. The records showed that the resident did not have an assessment done according to the home's procedure after they had sustained an unwitnessed fall and the family/SDM was not notified after the fall.

RNs and the DOC reviewed the clinical records for the identified residents and acknowledged that the home's policy and procedure related to HIR and notifying the SDM was not followed.

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

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

In accordance with LTCH Act, s. 20 (1) the licensee was required to ensure that every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

Specifically, staff did not comply with the home's policy titled, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, which indicated that any individual who witnesses or suspects abuse or neglect of a resident must notify management immediately. This includes immediately notifying the on call manager or general manager during after hours.

a) The inspection was completed related to a CI which reported verbal abuse from staff to resident. This incident was not reported to management until the next morning.

The DOC confirmed that staff did not immediately report the incident of staff to resident abuse. They also confirmed that staff did not comply with the home's policy titled, Zero Tolerance of Resident Abuse and Neglect: A Response and Reporting.

b) This inspection was done related to financial abuse.

A CI reported that an identified resident made care providers aware that they had received money in the mail and asked them to take it to the business office for deposit into their trust account. At that time, the office was closed, and staff gave the money to an RPN. The RPN did not secure the money in the home, and took the money with them. The office manager made several attempts to remind the RPN to return the money but after six weeks they notified the ED of the situation.

The Office Manager said that they were new to the home and did not know the process for reporting these types of incidents. It was not until six weeks later that they notified the ED of the missing money.

The licensee has failed to ensure that the policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with., to be implemented voluntarily.

WN #8: 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).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any equipment, supplies, devices, assistive aids, or positioning aids used by staff, were appropriate for the resident and based on the resident's condition, specifically wheelchair equipment for residents.

A review of clinical records showed that the home had provided an identified resident with an assistive device and the resident sustained a fall as the assistive device was not fully functional.

There was no documentation to indicate that the resident had been assessed for the

assistive device.

The Physiotherapist reviewed the clinical records for the resident and acknowledged that the home had provided the resident with the assistive device. They also acknowledged that the resident had not been assessed for the assistive device and that the device should not have been used.

The licensee has failed to ensure that any equipment, supplies, devices, assistive aids, or positioning aids used by staff, are appropriate for the resident and based on the resident's condition. [s. 30. (1) 2.]

2. The licensee has failed 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.

A review of clinical records for the identified resident showed that the resident required a personal assistive device as an intervention, however, the assistive device for the resident was not documented in their care plan.

PSWs acknowledged that the interventions for the residents were to be documented in their care plan to keep staff aware.

The RPN and the DOC reviewed the clinical records for the resident and acknowledged that the resident required the assistive device as an intervention but it was not documented in their care plan and should have been.

The licensee has failed to ensure that any actions taken with respect to resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that any equipment, supplies, devices, assistive aids, or positioning aids used by staff, are appropriate for the resident and based on the resident's condition, specifically wheelchair equipment for residents. The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The Head to Toe assessment, stated that the identified resident had compromised skin integrity.

The home's policy titled skin and wound program stated:
- To initiate one Bates-Jensen Wound Assessment Form watch open area/wound and keep in the treatment binder.
- Record the treatment regimen on the Medication Administration Record (MAR) and or Treatment Administration Record (TAR).

Record review showed that there was no assessment documented related to the altered skin integrity.

The RN reviewed the clinical record and stated that there was no skin assessment completed for the altered skin integrity issue and it was not identified on the TAR or the MAR.

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

This inspection was completed in relation to complaint submitted to the MOHLTC which reported that an identified resident had an area of altered skin integrity and it was not assessed for a specified time period before going to hospital to be assessed.

The Treatment Administration Record (TAR) was reviewed and there was no evidence of monitoring of the resident's altered skin integrity. There was no weekly re-assessment documented under the assessment tab.

The Registered Nurse (RN)\ Skin and Wound Lead and the DOC shared that once the altered skin integrity was noted, it should have been noted on the TAR and monitored until healed. The RN said that there was no weekly assessment done.

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The licensee shall ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the resident.

Two complaints were received by the MOHLTC related to an insufficient supply of linen.

At the time of the inspection there were 90 residents residing in the home.

The home's policy on linen quotas, stated that the support services manager should work together with the home to review the quota setting guidelines and make necessary changes to accommodate the needs of the home, taking into consideration the amount of linen required daily on each home unit and the level of care required. The policy also stated that there should be sufficient linen in the home for 2 to 2.5 days.

The home's 24 hour quota setting guideline for the linen to be supplied was:
• peri cloths given should be 1-2 per incontinent resident/shift
• hand towels - 1-2/day - per resident
• face cloths 1.5 -2 resident plus one per resident per scheduled bath day plus one per resident requiring total am care/bed bath
• bath towels - 2 to 3 per bath day to cover scheduled baths and demand baths
• sheets/pillowcases 2 top/bottom sheets and 2 pillow cases per each unites scheduled changes plus 2 top/bottom for demand changes (25% incontinent resident).

A notation made by the ESM on this document stated that they set out 60 hand and face towels for each wing/each shift (total of 180) and seven sheets and pillowcases (total 21 sets).

The homes tracking of the needs on the cart for 24 hours was documented as
• peri cloths - 126
• hand towels - 63
• face cloths - 63
• bath towels -13
• sheets – 14 fitted and 14 flat
• pillowcases- 14

Observations completed of the linen rooms accessible by front line staff showed there were bed spreads or comforters and a couple of pillows but there were no hand or bath towels, face clothes, peri clothes or bed linens. Each of the wings of the home was supplied with a linen cart in the morning and afternoon. Observations of the cart completed with the ESM, showed there was not a sufficient supply to provide hand towel, facecloth or bath towel and peri clothes for each resident of the home. Observation of the towel warmer in the tub rooms showed two bath towels on each. Observations completed of each resident room showed that there was a total of eight hand towels found in the bathrooms. Of these, only two of the rooms were private and the other bathrooms were shared by a minimum of four residents. Of note, there was disposable paper towels

available in each bathroom.

Six staff reported that there was a shortage of linen. Two staff stated that the linen that was used in the morning needed to be laundered in order for there to be linen available to subsequent shifts and that sometimes bed making was delayed if there was not sufficient clean linen available. Staff reported that a laundry cart was delivered to the units each shift. If additional linen supplies were required they could look in the laundry area after hours to see if there was linen still needing to be folded, or during business hours they could speak to the Environmental Services Manager (ESM).

The ESM stated that a cart was supplied to each wing in the morning and evening and there should be sufficient linen for 24 hours.

The DOC acknowledged that there had been ongoing concerns related to there being insufficient linen available. When they reviewed the 24 hour quota documentation the DOC stated that there was not sufficient bed linens for the home.

The licensee had failed to ensure that there was a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the resident. [s. 89. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that there is a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the resident, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to ensure that all medical directives or orders for the administration of a drug to a resident were reviewed at any time when the resident's condition was assessed or reassessed in developing or revising the resident's plan of care.

This inspection was completed related to a complaint submitted to the MOHLTC which reported medication incidents for an identified resident after readmission from the hospital.

The policy called Medication Reconciliation under procedure stated that
1. A complete an accurate Best Possible Medication History (BOMH) of the resident medication including name, dose, route, the frequency and corresponding diagnosis.
2. Use the BPMH to identify and resolve differences and discrepancies against the resident's admission, transfer or discharge medication orders.

A medication incident report indicated that there were a number of missed medications for the identified resident when medication reconciliation was completed upon readmission from hospital. The medication incident also indicated that the resident did not receive the missed medications and there was harm to the resident with negative outcome.

A note attached to the medication incident report from registered staff (responsible for

the medication reconciliation) stated that they "made a huge medication error and marked the wrong column while aware that there were no changes to the medications other than a few".

The registered staff stated that they used the medication reconciliation form from pharmacy to complete the medication reconciliation for all residents upon admission or readmission. They shared that the charge nurse prepared the medication reconciliation by creating a list of medication and reviewing the orders against the transfer or a discharge medication order. They then communicate the list to the physician to reconcile and confirm the orders. The registered staff said that there were two other nurses that also did the checks once the medication was ordered. They said that the second check was done by a different nurse and they reconciled the orders against the Medication Administration Record (MAR) and the third check was done against the medication strips or cards to ensure that the right medication was received. A total of three different nurses looked at the orders. The medication review report noted that there were three different signatures from the registered staff confirming that the orders were correct and medications were still missed.

The DOC said that medication reconciliation was an issue when the resident was re-admitted back from the hospital.

The licensee failed to ensure that all medical directives or orders for the administration of a drug to a resident were reviewed at any time when the resident's condition was assessed or reassessed in developing or revising the resident's plan of care. [s. 117. (a)]

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 The licensee shall ensure that all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care., to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

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

This inspection was completed related to a complaint submitted to the MOHLTC in relation to medication errors for an identified resident.

A Medication incident report indicated that drugs were not administered to residents in accordance with the directions for use specified by the prescriber.

The DOC acknowledged that drugs were not administered to the resident in accordance with the directions for use specified by the prescriber and there was a medication error form completed.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

2. The licensee has failed to ensure that no resident who was permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident.

This inspection was completed related to a complaint submitted to the MOHLTC which reported that the identified resident's medications were found in resident's room.

Review of the medication incident report stated that the PSW found drugs in the resident's shirt and one on their shoe and both tabs were returned to the registered staff. The medication incident report stated that the registered staff did not watch the resident take pills and it further stated that they were going to make a progress note for the registered staff to ensure that they watch the resident take their pills. The complaint was addressed with the POA.

Review of a "Complaint Investigation Form", indicated that the pills were still being found in pockets and bed sheets.

Physician orders were reviewed and there were no orders related to self-administration of medication and storage of the medication in their room.

The DOC stated that there were times where the registered staff were leaving medications in the room and communication was put out to staff not to leave the medication unattended. [s. 131. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident., to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

A complaint was received by the MOHLTC which stated that there was no call system in the hairdressing suite to alert staff to possible emergencies.

Observation of the hairdressing suite did not show evidence of a call system in place.

Interviews with the hairdresser and PSW acknowledged there was no call system in the hairdressing suite. They said the hairdresser would call out to staff from the hall if they needed assistance with a resident as the door to the salon was open when they were present.

The ED stated they had no recollection that there was no call system in the hairdressing suite.

The licensee had failed to ensure that the resident-staff communication and response system was available in every area accessible by residents. [s. 17. (1) (e)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; specifically improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm

a) A complaint was received by the MOHLTC for an identified resident, which alleged neglect of the resident by staff with respect to completing personal care and their activities of daily living. The POA met with the Administrator of the home and alleged staff were not providing proper care. The Administrator informed the POA that they would put in a critical incident (CI) to the MOHLTC.

Review of CI's on the long term care homes website did not show evidence of a CI for this incident.

The DOC stated that the home should have completed a CI for this incident and acknowledged that one had not been completed.

The licensee had failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; specifically improper or incompetent treatment of care of resident that resulted in harm or a risk of harm.

b) The home contacted the Service Ontario After-Hours Line to report an incident of staff to resident abuse a day after the incident had occurred and the home submitted a critical Incident (CI) report to the Director four days after the incident.

The DOC stated that the incident of staff to resident abuse that occurred was not reported to the Director immediately and it was considered late reporting. (532)

The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by staff that resulted in harm, immediately reported the suspicion and information upon which it was based to the Director. [s. 24. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident was provided with a range of continence care products that properly fit the resident.

A complaint was received by the MOHLTC which alleged that the continence care products used were causing discomfort.

Review of the progress notes in Point Click Care (PCC) for the resident documented a concern which stated that the resident's continence care products were uncomfortable. The progress note indicated that the Administrator and resident problem solved and came up with a plan to address the resident's concern. Documentation indicated that the Administrator spoke to the DOC related to alternative continence product and suggested a different continence care product as an option.

Review of incontinent product assessments did not reveal any reassessment or measurement of the resident for an alternative continence product.

Review of the care plan for resident did not show any change in the continence care product, only a note that the resident would complain of the continence care products being uncomfortable.

The DOC acknowledged awareness of concerns related to the resident's continence care products not fitting properly.

The licensee has failed to ensure that the resident was provided with a range of continence care products that properly fit the resident. [s. 51. (2) (h) (ii)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 13th day of February, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère 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) :	NUZHAT UDDIN (532), JANETM EVANS (659)
Inspection No. / No de l'inspection :	2018_601532_0026
Log No. / No de registre :	028524-16, 032386-16, 002526-17, 004508-17, 016792-17, 020872-17, 025272-17, 029666-17, 006077-18, 006626-18, 008193-18, 008970-18, 009164-18, 011457-18, 018328-18, 018565-18, 021726-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 11, 2019
Licensee / Titulaire de permis :	CVH (No. 2) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Maitland Manor 290 South Street, GODERICH, ON, N7A-4G6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Amanda Beddow

Ontario

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

Ministère 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

To CVH (No. 2) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

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

Ministère 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

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 complaint with s. 8 (3) of the LTCHA.

Specifically, the licensee 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.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement.

A complaint was received by the Ministry of Health and Long Term Care (MOHLTC) which alleged a shortage of staff and stated that at times there was no Registered Nurse (RN) in the building.

Review of staff schedules over 25 weeks, showed 12 RN shifts out of a possible 374 shifts (or three per cent) that were filled by either agency staff or one of the home's Registered Practical Nurses (RPNs) working the shift.

Maitland Manor Nursing and PSW Staffing Services Quality Program Evaluation for staffing (2017) documented that there were over six shifts where there was no RN in the home and the home's bed size exceeded 64 beds.

The Ward Clerk stated RNs worked 12 hour shifts. There was one RN on days and one on night shift. They stated that there were times when they were unable to fill vacant RN shifts and the home would try to cover the shift using an agency RN or have one of the home's RPNs work the shift with an RN on call as back up.

The DOC acknowledged the use of agency staff or the home's RPNs to cover RN shift vacancies.

The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement. [s. 8. (3)]

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 3 widespread as it had the potential to affect a large number of LTCH residents. The home had a level 3 history, with one or more related noncompliance (NC) in last 36 months with this section of the LTCHA that included:

Voluntary plan of correction (VPC) issued August 28, 2017 (2017_628680_0005. (659)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 29, 2019

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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be complaint with s. 19 (1) of the LTCHA.

Specifically, the licensee shall ensure:

a) All identified residents and all other residents of the home are protected from abuse by anyone.

b) All identified residents and all other residents of the home are not neglected by the licensee or staff.

c) That an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it. The analysis should include; measures, strategies and improvements made to prevent further occurrences and a written record is kept of everything.

d) All staff at the home are trained on the licensee's prevention of abuse policy including:

i) The definitions of abuse and neglect.

ii) Training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for residents care.

iii) Situations that may lead to abuse and neglect and how to avoid such situations.

e) The home evaluates the effectiveness of the abuse and neglect training and that a record is kept of both the training and the evaluation.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purpose of the ACT and this Regulation (O.Reg. 79/10, s. 5.) neglect is defined as the failure to provide residents with the treatment, care services or assistance required for health, safety or well-being, and includes inaction or pattern of inaction that jeopardizes the health, safety or well- being of one or more residents.

For the purposes of the definition of "abuse" in subsection 2(1) of the Act,

Verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature, or any form of verbal communication of a belittling or degrading nature, which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Financial abuse is defined as any misappropriation or misuse of a resident's money or property.

A Critical Incident submitted to MOHLTC alleged neglect of an identified resident.

Review of the clinical record for an identified resident showed that the resident required assistance with activities of daily living, however, they were left unattended for a prolonged period of time. The resident sustained injures related to this incident.

The DOC acknowledged that the identified resident had been left unattended for a prolonged period of time and stated that staff had not gone back to check on the resident. (659)

2. A Critical incident submitted to the MOHLTC, stated that an identified resident sustained a fall with injury while using a personal assistive device. The RPN who arrived at the scene observed the resident on the floor and told the PSWs to get the Registered Nurse (RN) as they were going on break.

The RPN acknowledged that they did not assess the resident before going on break and left them on the floor waiting for another registered staff.

(532)

3. This inspection was done based on a CI related to financial abuse.

The CI report stated that an identified resident made care providers aware that they had received money and asked them to take it to the business office for deposit into their trust account. At that time, the office was closed so staff gave the money to an RPN to secure within the home until it could be deposited through the office manager. The RPN did not secure the money in the home, but took the money with them. The office manager made several attempts to remind the RPN to provide the money, but, was unsuccessful. Six weeks later the office manager made the Administrator aware of the incident. The Administrator and the DOC met with the RPN who said they had forgotten to return the money.

The DOC acknowledged that an RPN had taken the resident's money with them and several attempts were made to ask them to bring the money back but it was not returned for six weeks. (532)

4. A complaint was submitted to the MOHLTC which reported that an identified resident had altered skin integrity before they were assessed at the hospital and diagnosed.

A clinical record note indicated that the identified resident had altered skin integrity. However, there was no documentation or assessment of the altered skin integrity for specified period of time after the initial assessment was done. The POA for the resident complained about the altered skin integrity.

The resident was assessed in the Emergency department and a diagnosis was made.

The Director of Care (DOC) acknowledged that there was a gap from the time the altered skin integrity was noted to the time the resident was assessed at the hospital. The DOC said that staff did not take action in terms of addressing the skin issue.

(532)

5. A CI reported that an identified resident initiated their call bell and it was not answered for a while.

Clinical records noted that an RN heard loud talking coming from the identified resident's room. When they entered the room, they found a staff member being verbally abusive towards the resident. The resident was observed to be emotionally upset by the incident.

A review of the home's internal investigation records showed the home considered the incident to be abuse and disciplinary measures were taken.

The licensee has failed to ensure that residents are protected from abuse by staff in the home and free from neglect by the licensee or staff in the home.

The severity of this issue was determined to be a level 3 as there was actual harm to residents. The scope of the issue was a level 3 widespread as 5 out of 6 residents reviewed were negatively affected. The home had a level 2 history with one or more unrelated NC in last 36 months. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 29, 2019

Ontario

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

Ministère 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

Order # / Ordre no : 003

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 complaint with O. Reg. 79/10, s. 31(3).

Specifically, the licensee shall ensure:

a) The staffing plan provides 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) The staffing plan shall include a back up plan to ensure missed baths are completed.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with resident's assessed care and safety needs.

Four complaints were received by the MOHLTC over an eight month period, which alleged a shortage of staff and that residents were not being bathed,

assistance with feeding residents was not timely and meals were cold, bed linens or resident's clothing were not being changed.

The staffing plan directed staff: If working more than two PSW's short, both bath aides were pulled and would fill in for that area. Staff were encouraged if they had time to complete baths for their section.

A memo related to working short, from the Director of Care stated that "as a team you were to decide who gets bathed when the bath nurse was on her half bath shift routine".

The home's policy related to Assignment of Resident Care, stated that the Director of Care would establish a system for reviewing the care requirements for residents in the home and assigning staff to provide the required care on a 24 hour basis. The procedure included that the nurse would assign unit staff to provide the required care to each resident on the unit and there would be a reassignment of residents if they were working short.

The Ward Clerk stated that PSWs worked eight hour shifts. There should be 10 scheduled to work on day shift, nine on evening shift and four on night shift. The Ward Clerk said when the census was up for the home they tried to fill shifts and offered overtime as needed for call ins. The Ward Clerk stated that there were six part time lines on day shift, two on evening shift and one on night shift that were vacant.

Review of the PSW schedule for August 2017 showed 31 out of 93 shifts (33 per cent) there was a shortage of PSW staff. Seven of these shifts (eight per cent) they were short two and half PSWs or more.

Review of the PSW schedules for a 21 week period from March 19, 2018 to November 30, 2018 showed a shortage of PSW staff on 212 out of 435 shifts (49 per cent). Thirty four of these shifts (16 per cent) were short by two and a half PSWs staff or greater.

Review of flow sheets for random residents related to bathing for August 2017 showed:
An identified resident received three of eight baths. On five of the days the

resident was to receive a bath the home was short PSWs.
An identified resident received six of eight baths. On one of the two days the resident was scheduled to have a bath the home was short PSWs.
An identified resident received six of eight scheduled baths. The resident's bath schedule had been altered to allow the six of eight baths to be administered. On four of scheduled bath days the home was short PSWs.

Review of flow sheets for October to November 2018 showed:
An identified resident received six of eight baths. On two of the days the resident missed a bath, the home was short PSWs.
An identified resident received seven of eight scheduled baths for November 2018. On the day the resident missed a bath, the home was short PSWs.
An identified resident received six of eight scheduled baths in October. On the days the resident missed baths, the home was short PSWs.

The plan of care for each of the above resident's indicated the resident was to receive two baths per week.

In interviews with the identified residents they said that they had missed some of their baths.

PSWs said that usually eight to nine baths were completed on each wing on day shift and there were also baths completed on evening shift. If they were working short of PSWs, they would be pulled from the bath shift to work the unit. When they worked short, residents may not receive their baths. They documented baths on a hard copy flow sheet. The home did not track missed baths; if they were not able to make up the resident's bath, the bath would just be skipped until the next scheduled bath time. They said some residents would express concern about missed baths. A PSW said the home used to call in someone to help make up baths or to cover a shift if PSWs were working short but they no longer did this. A PSW stated the home may try to call staff in to work but there was no one to fill the shift, when it got to the end of a week they would pick and choose which residents to bathe based on who really needed the bath.

The DOC acknowledged a shortage of PSW staff and confirmed intermittent use of agency staff to try to fill the vacant shifts. The DOC acknowledged that when PSWs worked short, residents may be impacted by not having their baths

completed, not receiving a bath of their preference, bed linen not being changed or residents may not be dressed in street clothing.

The licensee had failed to ensure that the staffing plan provided for a staffing mix that was consistent with resident's assessed care and safety needs related to bathing. [s. 31. (3)]

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 2 pattern more than the fewest number of residents were affected. The home had a level 2 history with one or more unrelated NC in last 36 months. (659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 29, 2019

Ontario

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

Ministère 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

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. 245. The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act.
O. Reg. 79/10, s. 245.

Order / Ordre :

The licensee must be complaint with O. Reg. 79/10, s. 245.

Specifically, the licensee shall ensure:

a) That residents are not charged for continence management supplies that the licensee was required to provide to the resident using funding that the licensee received from the LHIN or accommodation charges received under the LTCHA.

b) That all identified residents and any other resident requiring continence care products are assessed and provided continence care products based on their individual assessed needs as outlined in the regulations, including a pull up style product;

c) Residents and families are made aware of the range of continence products available to them at no cost. Staff in the home communicate with all identified residents and any other resident currently providing their own continence product to ensure they are aware that there are a range of continence products available to them at no cost.

d) An audit is conducted of all residents that have lived in the home in the year of 2018 to determine if they had used or are using a pull up style continence product:

(i) When a pull up style product was/is used the home will determine, when the product was provided by the home, if the resident/representative was providing the product, and if the product was/is an assessed need.

(ii) When the product was provided by the resident/representative the licensee will reimburse all actual or estimated expenses incurred by the resident/representative in 2018, for the full cost of the products used.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were not charged for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a Local Health Integration Network.

Observations of continence supplies showed sufficient supplies with a range of products available from liners and pads to various sizes of briefs but not including pull-ups.

The resident profile worksheet indicated which incontinence product residents wore. There were eleven residents identified as using family supplied pull-ups.

The Office Manager stated that they had never billed residents for continence products but products may be ordered through the pharmacy on occasion and then pharmacy would do the billing for this.

The DOC acknowledged if a resident was admitted who used pull ups they were not always offered alternative products from the homes continence supplies to use and that families supplied and paid for pull ups for residents who used pull ups.

The licensee had failed to ensure that residents were not charged for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a Local Health Integration Network. [s. 245. 3.]

The severity of this issue was determined to be a level 1 as there was minimal risk to the residents. The scope of the issue was a level 3 widespread it represented systemic failure that affected 11 out of 11 residents and has the potential to affect a large number of LTCH's residents. The home had a level 2 history 1 or more unrelated NC in last 36 months. (659)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 29, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 11th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

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