Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 2, 2019	2019_725522_0014	015971-19	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Secord Trails Care Community
263 Wonham Street South INGERSOLL ON N5C 3P6

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

JULIE LAMPMAN (522)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 5, 6, 9, 10, 11, 12, and 13, 2019.

This inspection was completed concurrently with Critical Incident System report #2628-000025-19/Log #016180-19 related to resident to resident abuse.

During the inspection, Complaint IL-69336-LO/ Log #015971-19 related to sufficient staffing was inspected.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Director of Support Services, Scheduling Coordinator, a Registered Nurse, an agency Registered Practical Nurse, Personal Support Workers, an agency companion, residents and a family member.

The inspector also observed staff to resident interactions, the provision of resident care, reviewed resident clinical records, bathing schedules, daily rosters, the written staffing plan of the home, the annual staffing plan evaluation and policies and procedures related to this inspection.

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

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

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

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

An anonymous complaint was received by the Ministry of Long-Term Care which stated that the staffing levels in the home were not meeting the continence care, bathing and hygiene needs of residents.

Review of the home's draft Contingency Plan dated August 2019, provided by Executive Director #100 noted the following:

" We will make every effort to avoid staffing shortage. However, in the event that the team is working short, the RN should utilize the call-in process to find staff to fill the vacant positions and reach out to the contract agencies for coverage. Staff should work

in a collaborative effort to ensure that resident care is completed, focusing on the essential tasks."

The contingency plan indicated for Personal Support Workers (PSWs) stated in part:
For the 0600 to 1400 hour shift, there should be seven PSWs for three home areas and one PSW for bathing scheduled.
If one PSW short – "Utilizing the call in process, offer straight time to PSWs including any FT PSWs who are working less than 10 shifts in current pay period. If no one accepts straight time:
• If sick call is on Rose Lane, assignment #1 goes to fill sick call and offer overtime from 0600 - 1400 for Rose Lane.
• If sick call is bath shift, RN will ask for a volunteer to change assignments.
• If no volunteers, assignment #1 becomes bath shift and offer overtime from 0600 - 1400 for Rose Lane."

If two PSWs short: "Utilizing the call in process, offer straight time to PSWs including any FT PSWs who are working less than 10 shifts in current pay period. If no one accepts straight time:
• Re-assign bath shift to home area with only one PSW.
• If one of the sick calls is on Rose Lane, offer overtime from 0600 – 1400.
• If sick calls are on Rose Lane, assignment #1 goes to the sick call and offer overtime from 0600 - 1100 for Rose Lane.
• Offer overtime from 0600 - 1100 for bath shift (or adjust the 5 hours as necessary for 1400 - 2200 shift).
• If no one accepts overtime for the bath shift, PSW must complete bed baths and document.
• Contact on-call manager and at direction, contact agency for PSW coverage."

For the 1400 – 2200 hours shift, there should be seven PSWs for three home areas and one PSW for bathing scheduled.
If one PSW short: "Utilizing the call in process, offer straight time to PSWs including any FT PSWs who are working less than 10 shifts in current pay period. If no one accepts straight time:
• Offer a full 1400 - 2200 shift to the 1500-2100 (bath) assignment.
• Offer 3 hours of overtime for the bath shift.
• If 1500 – 2100 (bath) person cannot extend the shift to 1400 – 2200, then offer 4 hours for bath shift and 1500 – 2100 person will work in the area of the sick call."

If two PSWs short: "Utilizing the call in process, offer straight time to PSWs including any FT PSWs who are working less than 10 shifts in current pay period. If no one accepts straight time:
• Offer a full 1400 - 2200 shift to the 1500-2100 (bath) assignment.
• Offer overtime from 1700 – 2200 (or adjust the 5 hours as necessary for the 0600 – 1400 shift).
• Offer 3 hours of overtime for the bath shift.
• If 1500 – 2100 (bath) person cannot extend the shift to 1400 – 2200, then offer 4 hours for bath shift and 1500 – 2100 person will work in the area of the sick call."

For the 2200 – 0600 hours shift, there should be one PSW on each home area scheduled.
If one PSW short "Utilizing the call in process, offer straight time to PSWs including any FT PSWs who are working less than 10 shifts in current pay period. If no one accepts straight time:
• Offer overtime to PSWs.
• If no one accepts overtime, each PSW covers one and half home area.
• Registered staff on duty to assist PSWs as they are able."

On September 11, 2019, in an interview, ED #100 stated the home had just revamped their contingency plan and job descriptions for Personal Support Workers (PSWs). ED #100 stated the contingency plan had been reviewed by the registered staff. ED #100 stated they had told the registered staff that they had to lead and if the home was short staffed, registered staff needed to think of what they needed to do to assist.

A) In an interview, resident #004 stated they had missed their bath on a specific day as there were not enough staff working that day. Resident #004 stated they had not yet been offered a bath in place of the bath they had missed.

Two days later, resident #004 told inspector they were going down to have a bath as it was their normal bath day. Resident #004 stated they never received a bath to make up for the bath they missed.

Review of documentation from Point of Care (POC) for a specific date, noted resident #004 did not receive a bath as they had indicated.

Review of the daily roster noted that on the day resident #004 had missed their bath, there were two partially unfilled PSW shifts from 0600 – 1000 hours, an unfilled shift from

0600 – 1400 hours and two partially unfilled shifts from 1400 – 1800 hours.

In an interview, Personal Support Worker (PSW) #113 stated that they were the full time bath person from 0600 to 1400 hours. PSW #113 stated there was an afternoon bath person who worked 1400 to 2000 hours, and the floor PSWs on evenings were also scheduled some baths. PSW #113 stated on days when the home was two PSWs short they were pulled to help with resident care on the area that was short. PSW #113 stated there were times when afternoon staff would come in earlier at 1000 hours and then PSW #113 would return to baths and try to complete about four baths before the end of their shift. PSW #113 stated that this occurred a lot on the weekend, but they were now working short during the week.

PSW #113 stated when they were pulled to work on the floor, they were to offer baths to the residents who missed baths on their next shift. PSW #113 stated they had a hard time trying to pick up the baths that were missed and before they knew it, they had completed the second scheduled bath of the week for a resident and they had not made up the bath that was missed.

In an interview, PSW #114 stated on August 10, 2019, they started to keep a log of shifts that were short. PSW #114 stated to date there were 25 day and afternoon shifts that were short PSWs. PSW #114 stated staff would come in and work 12 hour shifts to cover part of a shift and to give the residents the care they deserved.

PSW #114 stated some days the home was short a PSW from 0600 to 1000 hours or a full shift from 0600 to 1400 hours. PSW #114 stated there were times the home was two or three PSWs short and afternoon PSWs came in at 1000 hours and worked 1000 to 2200 hours. PSW #114 stated staff could not catch up on what was missed, and ultimately baths were missed.

In an interview, PSW #102 stated that they were working short. PSW #102 stated that they were scheduled to work Rose Lane but because they were short a PSW they were pulled to work on Lilac Lane. PSW #102 stated that normally there were three PSWs scheduled for Rose Lane as there were more residents on that home area, there were two PSWs for Lilac Lane and two for Lily Lane and a bath person on day shift. PSW #102 stated when they were one PSW short a PSW was pulled from Rose Lane and they worked two PSWs on each home area. PSW #102 stated when there were two PSWs short the bath person was then pulled, and they worked two PSWs on each home area.

PSW #102 stated they had worked a recent weekend and had worked short PSW staff on both days. PSW #102 stated there were five PSWs working on the Sunday and six on the Saturday, when there should be a total of eight PSW staff.

PSW #102 stated on the Saturday, they were short a bath PSW and one PSW on the floor until 1000 hours, when two afternoon PSWs came in early. On the Sunday, PSW #102 stated there were five PSWs total, one PSW was on Lily by themselves, two PSWs were on Rose and two PSWs were on Lilac and there was no bath PSW. PSW #102 stated two PSWs came in at 1000 hours, leaving one PSW short on the floor. PSW #102 stated that on the weekend housekeeping and activation staff had helped porter residents.

PSW #102 stated they often worked short on weekends but lately they were working short during the week. PSW #102 stated at times they found it was hard getting resident care done on time for breakfast and to get everyone toileted after breakfast was sometimes impossible.

In an interview, PSW #103 stated that they had come in early and were working 1000 to 2200 hours, as Rose Lane was short a PSW from 0600 to 1400 hours. PSW #103 stated summer students had gone back to school which had caused the home to be short staffed on the weekends and during the week. PSW #103 stated baths were getting missed when they were working short.

Review of the home's bath schedule noted ten residents were scheduled daily for the 0600 – 1400 hour bath shift, eight residents were scheduled daily for the 1400 – 2000 hour bath shift and approximately four residents daily to be bathed by the evening floor PSW assigned to the resident.

The bath binder at the nurses' station was reviewed and noted a memo dated October 25, 2018, which stated in part, if a bath was missed, that the resident should be offered a bath on the next shift/day. All missed baths should be brought forward and completed before the next shifts/days bath.

Review of the communication notes in the bath binder from July 1, 2019 to September 12, 2019, noted 92 out of 269 (34.2%) baths were missed.

In an interview, Director of Care (DOC) #101 reviewed communication of missed baths in bath binder. DOC #101 acknowledged that residents had missed baths and that they had

not been offered another bath. DOC #101 stated that if a resident missed a bath, they should be offered a bath the next day or a bed bath if the resident was agreeable. DOC #101 stated that sometimes the bath person would work later to get baths done and they themselves had assisted with baths. DOC #101 stated they needed to monitor missed baths better.

B) Review of resident #007's most recent care plan in Point Click Care noted resident #007 required one person assistance with daily care.

On a specific date and time, resident #007 was observed seated outside the nurses' station in a chair. Resident #007 had a cup in their hand and was holding the cup upside down.

Inspector asked resident #007 if they needed assistance. Resident #007 gave inspector their cup and inspector noted that resident #007's lap and pants were wet from the spilled drink.

Inspector saw Personal Support Worker (PSW) #105 in the hallway handing out snacks. Inspector informed PSW #105 that resident #007 had spilled their drink on their pants and their pants were soaked. PSW #105 stated that they had just given resident #007 the drink. Inspector asked PSW #105 if they could assist resident #007 get out of their wet clothes and PSW #104 stated they would assist resident #007. PSW #105 then went into a resident's room with a snack.

Approximately 35 minutes later, Inspector returned to the floor and observed resident #007 in their room. Resident #007 was lying in bed on top of the covers. Inspector observed that resident #007 was still wearing their wet pants.

Inspector approached PSW #106 who was in the hallway. PSW #106 stated they were unable to speak with inspector as they were going in to check on resident #007.

A review of the home's daily roster noted on the specific date, the 0600-1400 shift was short a PSW from 0600-1000 hours.

In an interview, Director of Care (DOC) #101 stated when Inspector #522 informed PSW #105 that resident #007 was wet, PSW #105 should have assisted resident #007 right away. DOC #101 stated no one liked to be wet, and staff should never leave a resident wet. DOC #101 stated they would follow up with the PSW.

In an interview, PSW #106 stated that they were assigned to care for resident #007 on the specific date. PSW #106 stated that they were working short that shift. PSW #106 stated that PSW #105 did not make them aware that resident #007 was wet and needed to be changed until PSW #105 had seen Inspector #522 come out of resident #007's room. PSW #106 stated once they were aware the resident needed changed, they went and provided care to the resident. PSW #106 stated they had come in early and were working 1000 to 2200 hours, as the home was short a PSW. PSW #106 stated when they worked short staff tried to help each other as much as they could.

C) Resident #001's care plan noted that resident #001 was incontinent and required extensive assistance.

Review of resident #001's electronic kardex on PCC noted the resident was to be repositioned every two hours.

On a specific date, resident #001 was observed seated in at a table in the dining room for approximately three and a half hours, during which time inspector noted a faint odour of urine from resident #001.

Just before shift change, PSW #103 removed resident #001 from the dining room and wheeled resident #001 into their room.

In an interview, PSW #103 stated they were assigned resident #001 that day. PSW #103 acknowledged that resident #001 had been seated in the dining room since the morning and that they had not had time to provide continence care to resident #001 until they removed the resident from the dining room before shift change. PSW #103 stated that they had come in early and were working 1000 to 2200 hours, as they were short a PSW from 0600 to 1400 hours.

The following day, resident #001 was observed seated at a table in the dining room eating breakfast. During a continuous observation of approximately one and a half hours, resident #001 was not brought back to their room to have continence care provided or to be repositioned. Resident #001 remained seated at the same table and as staff were observed serving lunch, resident #001 was noted to be sleeping, with their head hanging down with their hair hanging in their face.

Just before shift change, resident #001 was observed in their room lying in bed sleeping.

Inspector spoke with PSW #114 who stated that they had just put resident #001 into bed.

The following day, resident #001 was observed seated at a table in the dining room having breakfast. Inspector observed that resident #001 was not brought back to their room prior to lunch to have continence care provided or to be repositioned. Just before shift change, resident #001 was observed sleeping in their bed.

In an interview, PSW #112 stated they were assigned resident #001 and they had put resident #001 to bed approximately twenty minutes earlier. PSW #112 stated they were working short and they did not normally care for resident #001. Inspector asked if it was normal for resident #001 to be up before breakfast until just before shift change, without being repositioned or continence care provided. PSW #112 asked PSW #108 if it was normal for resident #001 to still be up at this time. PSW #108 stated sometimes resident #001 did not get put back to bed until after 1400 hours, after the afternoon staff started their shift. Inspector asked if staff brought resident #001 back to their room during the day to provide continence care. PSW #112 and PSW #108 stated that they did not have time to do that and that resident #001 did not have continence care provided until they were put to bed in the afternoon. Inspector asked if the staff repositioned resident #001 when they were up. PSW #112 and PSW #108 stated they would look at resident #001 to see if they were tilted and they would adjust them if needed, but that would only be if they noticed resident #001 was leaning to one side. PSW #112 and PSW #108 stated that they were short staffed and did not have the time to provide continence care to resident #001 after they were up in their chair until resident #001 was put to bed in the afternoon.

A review of the home's daily roster noted the following unfilled or partially unfilled shifts on the days resident #001 was observed.

Day one, 0600-1400 shift was short a PSW from 0600-1000 hours.
Day two, 0600-1400 shift was short a PSW from 0600-1000 hours.
Day three, 0600-1400 shift was short a PSW from 0600-1400 hours and 0600-1000 hours.

Review of resident #001's electronic documentation in Point of Care (POC) from July 1 to September 12, 2019, noted the absence of documentation on the following shifts:

Continence Assistance:
July

Days - 9 out of 31 shifts (29%).
Evenings - 1 out of 31 shifts (3%)
Night - 1 out of 31 shifts (3%)

August
Days - 15 out of 31 shifts (48.3%).
Evenings - 5 out of 31 shifts (16.1%).
Night - 4 out 31 shifts. (12.9%).

September
Days - 7 out of 12 shifts (58.3%)
Evenings - 1 out of 12 shifts (0.8%).

Daily care needs:
July - 16 out of 31 day shifts (51.6%).
August - 20 out 31 day shifts (64.5%).
September - 9 out of 12 day shifts (75%).

Evening care needs:
July - 9 out of 31 evening shifts. (29%).
August - 8 out of 31 evening shifts (25.8%).
September - 2 out of 12 evening shifts (16.6%).

Night care needs:
July - 9 out of 31 night shifts. (29%).
August - 4 out of 31 night shifts (12.9%).
September -2 out of 12 night shifts (16.6%).

Turning and positioning:
July
Days - 16 out of 31 shifts (51.6%).
Evenings - 5 out of 31 shifts (16%).
Nights - 2 out of 31 shifts (6.4%).

August
Days - 21 out of 31 shifts (67.7%).
Evenings - Nine out of 31 shifts (29%).
Nights - Four out of 31 shifts (12.9%).

September
Days - 9 out of 12 shifts (75%).
Evenings - 3 out of 12 shifts (25%).
Nights - 2 out of 12 shifts (16.6%).

In an interview, Director of Care (DOC) #101 stated resident's who were incontinent should have continence care provided at a minimum three times during the day, with morning care, after breakfast, and after lunch. DOC #101 stated residents should also have continence care provided after supper and then at bed time and then a minimum of twice during the night shift.

DOC #101 stated that it was unacceptable that resident #001 had not had continence care provided from when they were up in the morning until just before shift change. DOC #101 stated the only reason staff would not provide continence care to a resident was if the resident refused, then staff would need to leave and reapproach the resident.

In an interview, DOC #101 acknowledged that charting on POC was not being completed for resident #001. DOC #101 stated staff should be charting that they took care of the resident's needs through each shift and staff should be charting on POC after care was provided.

D) Review of resident #002's electronic care plan on Point Click Care noted resident #002 required assistance with daily care.

The care plan noted that resident #002 was incontinent and required extensive assistance.

On a specific date, resident #002 was observed in their room after breakfast had started.

In an interview, PSW #109 stated that resident #002 had come down to the dining room at about 30 minutes after breakfast had started. Inspector asked if that was common for the resident to come down that late. PSW #109 stated that it was common for resident #002 to come down late for breakfast when they were working short and they were short one PSW that day.

The following day resident #002 was observed seated in the dining room, the resident was not dressed appropriately for the time of day.

Prior to lunch, resident #002 was observed dressed the same. A faint odour of urine was noted from the resident.

Twenty-five minutes after lunch had started, PSW #116 was observed taking resident #002 to the dining room for lunch. Residents were already in the dining room eating their meal.

In an interview, PSW #116 stated they were assigned to resident #002 today as they were working short. PSW #116 stated they had taken resident #002 down for lunch late. PSW #116 stated when they went to get resident #002 for lunch, they had to put resident #002 back to bed to provide continence care. Inspector asked if it was normal for resident #002 to be up before breakfast and then put back to bed in the afternoon. PSW #116 stated they did not know resident #002's routine. Inspector asked if resident #002 had been put back to bed after breakfast to have continence care provided. PSW #116 stated resident #002 did not have continence care provided after breakfast. PSW #116 stated they did not have time to get resident #002 up then put them to bed and get them up again for lunch. PSW #116 stated they only provided continence care to resident #002 before lunch because resident #002 was observed to need continence care.

Review of Point of Care (POC) documentation noted staff documented that resident #002 did not receive a bath as scheduled on a specific date.

A review of the home's daily roster noted the following unfilled or partially unfilled shifts:

The day resident #002 missed their bath, the 0600-1400 shift was short a PSW from 0600-1000 hours.
The first day of observations of resident #002, the 0600-1400 shift was short a PSW from 0600-1000 hours.
The second day of observations of resident #002, the 0600-1400 shift was short a PSW from 0600-1400 hours and 0600-1000 hours.

Review of resident #002's electronic documentation in POC from July 1 to September 12, 2019, noted the absence of documentation on the following shifts:

Continence Assistance:
September – 7 out of 12 days (58.3%) and 3 out of 12 evenings (25%)

August
Days - 12 out of 27 (44.4%)
Evenings - 8 out of 27 (29.6%)
Nights - 2 out of 27 (7.4%)

Daily care needs:
September - 10 out of 12 shifts (83.3%)
August - 20 out of 27 shifts (74%)

Evening care needs:
September - 4 out of 12 shifts (33.3%)
August - 14 out of 27 shifts (51.8%)

Night care needs:
September - 5 out of 12 shifts (41.6%)
August - 11 out of 27 shifts (40.7%)

Bathing: August - 2 out of 8 baths (25%)

In an interview, DOC #101 stated that it was unacceptable that resident #002 had not had continence care provided from when they were up in the morning until just before lunch. DOC #101 stated that breakfast was served from 0830 to 0930 hours and lunch was served from 1200 to 1300 hours and staff should have had residents down for their meal approximately 15 minutes prior to the start of the meal. DOC #101 stated that resident #002 should be brought down to meals on time and should be dressed appropriately.

DOC #101 acknowledged that charting on POC was not being completed for resident #002. DOC #101 stated staff should be charting that they took care of the resident's needs through each shift and staff should be charting on POC after care was provided.

E) Review of resident #003's most recent electronic plan of care on PCC noted that resident #002 required assistance with daily care.

The care plan noted that resident #003 was incontinent.

Review of the bath book communication noted resident #003 did not receive a bath as scheduled on a specific day. Documentation beside resident #003's name noted staff

worked short that day.

Review of the home's daily roster noted on the day resident #003 missed their bath, the 1400 - 2200 shift was short two PSWs.

Review of resident #003's electronic documentation in Point of Care (POC) from July 1 to September 12, 2019, noted the absence of documentation on the following shifts:

Continence Assistance:

September
Days - 8 out of 12 shifts (66.6%)
Evenings - 3 out of 12 shifts (25%)

August
Days: 15 out of 31 shifts (48.3%)
Evenings: 7 out of 31 shifts (22.5%)
Nights: 2 out of 31 shifts (6.4%)

July
Days: 11 out of 31 shifts (35.4%)
Evenings: 2 out of 31 shifts (6.4%)
Nights: 1 out of 31 shifts (3.2%)

Continence Intervention:
September
Evenings: 9 out of 12 shifts (75%)
Nights: 2 out of 12 shifts (16.6%)

August
Days: 18 out of 31 shifts (58%)
Evenings: 7 out of 31 shifts (22.5%)
Nights: 1 out of 31 shifts (3.2%)

July
Days: 13 out of 31 shifts (41.9%)
Evenings: 2 out of 31 shifts (6.4%)

Daily care needs:
September - 11 out of 12 shifts (91.6%)
August – 16 out 31 shifts (51.6%)
July – 13 out of 31 shifts (41.9%)

Evening care needs:
September - 8 out of 12 shifts (66.6%)
August – 10 out of 31 shifts (32.2%)
July – 7 out of 31 shifts (22.5%)

Night care needs:
September - 7 out of 12 shifts (58.3%)
August – 2 out of 31 shifts (6.4%)
July – 2 out of 31 shifts (6.4%)

Turning and positioning:

September
11 out of 12 days at 0600, 0800, 1000, and 1200 hours (91.6%)
5 out of 12 days at 1400 hours (41.6%)
6 out of 12 days at 1600 hours (50%)
8 out of 12 days at 1800 and 2000 hours (66.6%)
1 out of 12 night shifts (8.3%)

August
2 out of 31 days at 0000, 0200, and 0400 hours (6.4%)
10 out of 31 days at 0600, 0800, 1000 hours (32.2%)
1 out of 31 days at 1000 hours (3.2%)
13 out of 31 days at 1200 hours (41.9%)
3 out of 31 days at 1400 hours (9.6%)
5 out of 31 days at 1600 hours (16.1%)
6 out of 31 days at 1800hours (19.3%)
5 out of 31 days at 2000 hours (16.1%)
2 out of 31 night shifts (6.4%)

July
13 out of 31 days at 0600 and 0800 hours (41.9%)
13 out of 31 days at 1000 hours (41.9%)

14 out of 31 days at 1200 hours (45.1%)
4 out of 31 days at 1400 and 1600 hours (12.9%)
5 out of 31 days at 1800 and 2000 hours (16.1%)
1 out of 31 night shifts (3.2%)

August 2019 – Bathing: 1 out of 9 baths (11%)

In an interview DOC #101 acknowledged that charting on POC was not being completed for resident #003. DOC #101 stated staff should be charting that they took care of resident #003's needs through each shift. DOC #101 stated that staff should be charting on POC after care was provided.

F) On September 11, 2019 at 0915 hours, Personal Support Worker (PSW) #108 was observed taking a resident to the dining room. PSW #108 stated the resident was just going down for breakfast. PSW #108 stated some residents were brought down for breakfast now because they were working short.

On September 12, 2019 at 0900 hours, PSW #108 stated they still had two residents to get up for breakfast.

Observations at approximately 0915 hours, noted several residents were still in bed. PSW #116 stated that they were working two staff short and they had to pull the bath person to help so there would be no baths today. PSW #117 stated they still had three residents that were in bed and needed to get up for breakfast. PSWs #116 and #117 were working together to get the residents up.

At approximately 1147 hours, PSW #116 stated a PSW came in at 1000 hours, and they were only one PSW short at that time.

A review of the home's daily roster noted the following unfilled or partially unfilled shifts:

September 11, 2019, 0600-1400 shift was short a PSW from 0600-1000 hours.
September 12, 2019, 0600-1400 shift was short a PSW from 0600-1400 hours and 0600-1000 hours.

Observations on September 11 and 12, 2019, noted Director of Support Services (DSS) #111 answering resident call bells. The Office Manager and recreation staff were also observed portering residents to the dining room and back to their room after meals.

In an interview, DSS #111 stated if they were on a wing and a resident's call bell was on, they would answer the call bell. DSS #111 stated if it was something they could help with they would assist the resident but if a resident needed personal care, they would let staff know.

DSS #111 stated in each department the home tried to cross train staff in different areas, that way if PSW staff were short on a shift they could call people in to porter residents or to come in early to assist with beds.

In an interview, DOC #101 stated that breakfast was served from 0830 to 0930 hours, and lunch was served from 1200 to 1300 hours. DOC #101 stated staff should have residents down for their meal approximately 15 minutes prior to the start of the meal. DOC #101 stated when staff were working short recreation staff, housekeeping staff and managers would help to porter residents, assist residents with dining and if staff were trained, they would help feed residents.

G) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to an incident of resident to resident abuse.

Review of the CIS report noted a Personal Support Worker (PSW) had observed the incident between resident #010 and resident #009.

Review of risk management on Point Click Care related to the incident noted that the incident occurred when the Registered Nurse was on break and the PSWs had reported the incident to the Registered Practical Nurse (RPN) on the floor.

Review of the CIS report provided by Director of Care (DOC) #101 noted a hand written account of the incident from PSW #112 and PSW #114. At the bottom of the note it stated, "PSW working 3 short."

A review of the home's daily roster for the date the incident occurred, noted there were two unfilled shifts and the bath shift was unfilled for two hours. Two agency Registered Practical Nurses (RPNs) were working with the Registered Nurse.

In an interview, Personal Support Worker (PSW) #112 stated that they had found resident #010 and #009. PSW #112 stated they were working short that shift and the PSW assigned to the home area where resident #010 resided, was on break. PSW #112

stated the registered staff working was covering the home area while the PSW was on break, which was part of the home's contingency plan.

In an interview, Director of Care (DOC) #101 was asked if they had considered that staffing levels might have contributed to resident #010 wandering from their room at the end of one home area, which was short two staff, to resident #009's room which was at the end of another home area. DOC #101 stated that they had not considered staffing levels as a contributing factor and that there were two PSWs and a RPN on the floor when the incident occurred.

H) A review of the home's staffing schedule provided by Scheduling Coordinator #107 noted the following unfilled staff lines:

Two Registered Nurse (RN) lines - Two nights in a two week period and four nights in a two week period.
One Registered Practical Nurse (RPN) line – Two days in a two week period.
Five Personal Support Worker (PSW) lines:
Line 8 – Permanent Part Time 15 hours - Two days in a two week period (Saturday and Sunday).
Line 11 - Four days in a two week period (Saturday, Sunday, Friday, and Tuesday).
Line 12 - Two evenings in a two week period (Saturday and Sunday).
Line 13 - Two evenings in a two week period (Saturday and Sunday).
Line 15 - Four evenings in a two week period (Saturday, Sunday, Friday, and Tuesday).

Review of the home's Daily Roster from July 1 to September 15, 2019, noted the following:

One RN was scheduled 0700 -1500, 1500 - 2300 and 2300 - 0700 hours.
Two RPNs were scheduled 0700 - 1500 and 1500 - 2300 hours and one RPN 2300 - 0700 hours.
PSWs:
Days 0600 - 1400 hours - Three PSWs on Rose Lane, two on Lilac Lane, two on Lily Lane and one bath PSW.
Evenings – 1400 - 2200 hours- Three PSWs on Rose, two on Lilac, two on Lily and one bath PSW (1400 - 2000 or 1500 - 2100 hours).
Nights - 2200 - 0600 – Three PSWs, one on each wing.

The roster stated, "If there is a staffing shortage, please follow the contingency plan

located in the front of the call-out binder."

Review of the daily roster of scheduled shifts from July 1 to September 15, 2019, noted the following full or partial unfilled PSW shifts:

July
0600 – 1000 hours – 7 shifts
0800 – 1400 hours – 1 shift
0830 – 1400 – 1 shift
0600 – 1400 – 2 shifts
1400 – 2200 – 6 shifts
1800 – 2200 – 2 shifts

August
0600 – 1000 – 11 shifts
0600 – 1030 – 1 shift
0600 – 1200 – 1 shift
0600 – 1400 – 5 shifts
1400 – 1800 – 1 shift
1400 – 2200 – 9 shifts
1600 – 2200 – 1 shift
1800 – 2200 – 1 shift
2200 – 0600 – 2 shifts
0200 – 0600 – 1 shift
Bath shift – 1800 – 2000 – 5 shifts
Bath shift – 0600 – 1000 – 1 shift

September
0600 – 1000 – 12 shifts
0600 – 1400 – 5 shifts
0900 – 1000 – 1 shift
1400 – 1800 – 5 shifts
1400 – 2200 – 1 shift
1800 – 2200 – 2 shifts
Bath shift – 0600 – 1400 – 2 shifts
Bath shift – 1700 – 2000 – 1 shift
Bath shift 1800 – 2200 – 1 shift

Review of the daily roster dated Sunday, August 25, 2019, noted there were two PSWs short from 0600 – 1000 hours. There were no notes on the bottom of the roster which indicated additional assistance from other departments during the shortage.

Review of the daily roster dated Saturday, August 31, 2019, noted there was a PSW short from 0600 – 1000 hours and a PSW short from 0600 - 1400 hours. There were no notes on the bottom of the roster which indicated additional assistance from other departments during the shortage.

Review of the daily roster dated Saturday, September 7, 2019, noted the 0600 – 1400 shift was short two PSWs from 0600-1000 hours. An evening PSW was scheduled to work 1000-2200 hours and another PSW was scheduled from 1000 – 1400 hours. Another PSW 0600 – 1400 shift was short a PSW from 0900 - 1000 hours. The PSW scheduled the previous night stayed until 0900 hours and the evening PSW came in early and worked 1000-2200 hours.
There was no 0600-1400 bath PSW scheduled and the 1400-2200 shift was short a PSW from 1400-1800 hours.

A note on the bottom of the daily roster noted a program staff member was scheduled 0730 -1130 hours, to help with the PSW shortage, and a laundry staff member was scheduled at 0800 hours, to help porter residents and other laundry staff were to assist as well.

Review of the daily roster dated Saturday, September 14, 2019, noted the 0600 - 1400 shift was short two PSWs from 0600-1000 hours. Two evening PSWs were scheduled to come in early to work 1000 - 2200 hours. The bath PSW shift was short from 1700 - 2000 hours.

A note on the bottom of the daily roster indicated a laundry staff member was scheduled at 0900 hours, to help porter residents to and from the dining room. A program staff member was scheduled at 0830 hours, to help with breakfast and to porter residents.

In an interview, Scheduling Coordinator (SC) #107 stated the home had a contingency plan that they used for scheduling when they were short staffed. SC #107 stated that if there was one PSW short on days or evenings they would schedule two PSWs on each wing. If there were two PSWs short, then the bath PSW would be pulled to work on the floor and there would be two PSWs per wing.

SC #107 stated that they recently had seven nursing students return to school who had been taking a lot of the empty shifts over the summer. SC #107 stated there were seven empty PSW lines, one RPN and two RN lines, all of which were part time. SC #107 stated that for the PSW lines two were being filled by current staff and two or three new PSWs were starting and that would help with some of the empty lines. SC #107 stated the RN lines were filled by casual staff and they used agency staff as needed for the RPN line. SC #107 stated they had difficulty with agency PSWs and currently were not using agency PSW staff.

In an interview, SC #107 reviewed the daily roster from July 1 to September 15, 2019, with inspector and confirmed the unfilled and partially filled shifts. SC #107 stated when they had unfilled shifts, they tried to have a PSW come in early for a shift or stay later after their shift to help with coverage.

SC #107 stated every other Friday on the schedule was the worst to book as they started with eight unfilled shifts to fill. SC #107 stated on Saturday, September 14, 2019, program staff would come in to help to feed and porter residents and make beds.

SC #107 stated that although it was not documented on the roster, on Sunday, August 25, 2019, when the 0600 – 1400 hour shift was short two PSWs from 0600 – 1000 hours, they would have tried to get other staff to come in to assist and the Oncall Manager would have come in. SC #107 stated that DOC #101 came in that day to assist.

In an interview, Executive Director (ED) #100 stated every morning they had a risk management meeting and reviewed 24-hour report, staffing for the day and for the next week and the plan to cover shifts. ED #100 stated if baths were not completed on a shift, they were carried forward to the next shift. ED #100 stated the evening bath shift was not a full shift so if a bath was not completed in the morning they would try and have the evening person stay later or come in earlier. ED #100 stated they had identified earlier in the year that baths were not happening until the next bath cycle and addressed this with staff that this could not happen.

ED #100 stated that they were trying to hire to fill the vacant lines. ED #100 stated they did use agency staff to fill registered staff lines, but the home had not had success with using agency PSWs. ED #100 stated they were currently in the process of interviewing and hiring PSWs.

ED #100 stated when the home was working short PSWs they looked at who else was in

the building – housekeeping, laundry, maintenance, office staff, management. ED #100 stated those staff could make a bed, porter residents and if trained, could assist with feeding. ED #100 stated they also extended shifts or had brought in staff from other departments to help with tasks when needed.

ED #100 stated they had recent retirements, terminations and had summer students return to school which had affected the staffing schedule. ED #100 stated they recently hired two new PSWs that started this week and they were checking references on three other PSW candidates.

ED #100 stated they knew the home did not always have enough staff, but the essentials were done and the residents were safe and happy.

In an interview, Director of Care (DOC) #100 acknowledged the number of unfilled and partially filled shifts. DOC #101 stated when the home was short staffed, they would put the contingency plan in place. DOC #101 stated if there was a shortage of PSWs they asked for help from other departments and managers would also assist. DOC #101 stated any staff could answer a call bell and if needed get the PSW. DOC #101 stated staff also helped to porter residents to meals when needed and managers would assist with feeding. DOC #101 stated they had also helped with baths when needed.

When asked by inspector if the current staffing level met the needs of residents, DOC #101 stated they believed staff provided the required care to residents, but that it was not reflected in the staff's documentation of the care provided. DOC #101 stated they felt staff were choosing to provide care over documentation.

Base on interviews, observations and record reviews the home has failed to ensure that the written staffing plan of the home met the care and safety needs of residents and promoted continuity of care related to regular PSW staff shortages.

The home had been operating on their contingency plan several times per week for 10 weeks. From September 3 to 15, 2019, the home had been operating on their contingency plan daily. During this time, residents did not receive two baths per week, and observations noted residents did not receive continence care, turning and repositioning, were not brought down for meals on time, and documentation was not completed.

The licensee has failed to ensure that the written staffing plan provided for a staffing mix

that was consistent with residents' assessed care and safety needs. [s. 31. (3)]

2. The licensee failed to ensure that the written record of each annual evaluation of the staffing plan included a summary of the changes made and the date that those changes were implemented.

Review of the home's "Quality Management - LTC Program/Committee Evaluation Tool" dated March 2019, noted the Staffing Plan Evaluation was reviewed for the period of January to December 2019.

Goals and objectives for the period under review were noted as:
1. To hold quarterly Scheduling Committee meetings with union reps
2. To review Contingency Plans for staffing shortages annually
3. Ensure adequate number of staff are hired and orientated to ensure vacation and sick replacement
4. Analyze and trend any times during the calendar year when staffing was a challenge and replacements led to overtime.
5. Minimize turn over through positive staff recognition by holding staff awards, department recognition events for all departments, regular use of spot awards.
6. Enhance partnerships via job fairs, student placement opportunities - attend one job recruitment event every year.
7. Maximize nursing staff based on annual CMI results
8. Implement the Sienna attendance monitoring program

The review did not indicate a summary of any changes made and the date that those changes were implemented.

On September 11, 2019, in an interview, Executive Director #100 stated that some of the changes had been implemented, such as the attendance monitoring program, scheduling committee meetings and they had revised the home's contingency plan and PSW and Dietary job descriptions.

ED #100 acknowledged that they had not updated the evaluation to include any changes made and the date those changes were implemented.

The licensee failed to ensure that the written record of each annual evaluation of the staffing plan included a summary of the changes made and the date that those changes were implemented. [s. 31. (4)]

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 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:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of special treatment and interventions, with respect to the resident.

Resident #002 was admitted to the home on a specific date.

Review of resident #002's Admission Minimum Data Set (MDS) Assessment, noted resident #002 required a specific intervention.

Resident #002's care plan and kardex did not indicate that resident #002 required the specific intervention.

Review of documentation in Point of Care for resident #002 noted the absence of a supportive action for the specific intervention and therefore there was no documentation that resident #002 received the intervention.

In an interview, Director of Care (DOC) #101 reviewed resident #002's plan of care with inspector. DOC #101 acknowledged that there was no focus in resident #002's plan of care related to the specific intervention. DOC #101 stated that resident #002 required the specific intervention and the intervention should be reflected in resident #002's care plan and kardex. DOC #101 stated that registered staff were responsible to ensure that the information regarding the specific intervention was in resident #002's plan of care.

The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of special treatment and interventions, with respect to resident #002. [s. 26. (3) 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 plan of care is based on, at a minimum, interdisciplinary assessment of special treatment and interventions, with respect to the resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1.The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

On a specific date and time, resident #003 was observed outside their room. Inspector noted that Personal Support Workers had gotten resident #003 up for a meal. Resident #003 was not dressed appropriately for the time of day.

Later that same day, resident #003 was observed in their room. Resident #003 was still not dressed appropriately for the time of day.

The following day, in an interview with resident #003's spouse. Resident #003's spouse stated that sometimes resident #003 was not dressed for the time of day but that was not often.

The following day, resident #003 was observed in their room. Resident #003 was not dressed appropriately for the time of day.

Review of resident #003's most recent electronic plan of care on Point Click Care noted that the plan of care did not indicate how resident #003 was to be dressed throughout the day.

In an interview, Director of Care (DOC) #101 stated that resident #003's family was agreeable for resident #003 to be dressed the way inspector had observed resident #003. DOC #101 stated that this should be included in resident #003's care plan.

The licensee has failed to ensure that the care set out in the plan of care related to dressing was based on the needs and preferences of resident #003. [s. 6. (2)]

Issued on this 2nd day of October, 2019

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE LAMPMAN (522)
Inspection No. / No de l'inspection :	2019_725522_0014
Log No. / No de registre :	015971-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 2, 2019
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Secord Trails Care Community 263 Wonham Street South, INGERSOLL, ON, N5C-3P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JoAnn Zomer

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., 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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # /
Ordre no : 001

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) of O. Reg 79/10.

Specifically, the licensee shall ensure the following:
a) Ensure that residents #002, #003, and #004, and all other residents, are bathed at a minimum twice a week by the method of their choice and bathing is documented.
b) Ensure that residents #001 and #002, and all other residents that require staff assistance with turning and repositioning, are turned and repositioned every two hours and turning and repositioning is documented.
c) Ensure that residents #001 and #002, and all other residents receive continence care before and after meals and continence care is documented.
d) Ensure resident #003 and all other residents that have specific interventions related to continence, have those interventions provided and documented.
e) Ensure resident #007 and all other residents receive the required assistance with personal care, and personal care is documented.
f) Ensure that resident #002 and all other residents are dressed appropriately, suitable to the time of day and dressing care is documented.
g) Ensure that resident #002 and all other residents that require assistance to get to the dining room for meals are brought down to meals prior to the start of the meal service.
h) Ensure resident care, as per the resident's individualized plan of care, is documented in Point of Care.
i) Develop and implement an auditing process to ensure that all residents receive two baths per week by the method of their choice, receive continence care and assistance with turning and repositioning as per their individualized plan of care and that resident care is documented in Point of Care. A documented record of these audits must be kept in the home and must include the dates conducted, the names and signatures of the participants, the results of the review and what changes were implemented as a result of the review.
j) Evaluate and revise the home's staffing plan and "Contingency Plan" document to ensure the staffing compliment meets the assessed care and safety needs of the residents of the home, until such a time that the home is fully staffed, according to the staffing plan. The evaluation and revision must be documented including the date it was conducted, the
names and signatures of the participants, the results of the evaluation and what was done with the results of the evaluation.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

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

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

An anonymous complaint was received by the Ministry of Long-Term Care which stated that the staffing levels in the home were not meeting the continence care, bathing and hygiene needs of residents.

Review of the home's draft Contingency Plan dated August 2019, provided by Executive Director #100 noted the following:

" We will make every effort to avoid staffing shortage. However, in the event that the team is working short, the RN should utilize the call-in process to find staff to fill the vacant positions and reach out to the contract agencies for coverage. Staff should work together in a collaborative effort to ensure that resident care is completed, focusing on the essential tasks."

The contingency plan indicated for Personal Support Workers (PSWs) stated in part:
For the 0600 to 1400 hour shift, there should be seven PSWs for three home areas and one PSW for bathing scheduled.
If one PSW short – "Utilizing the call in process, offer straight time to PSWs including any FT PSWs who are working less than 10 shifts in current pay period. If no one accepts straight time:
• If sick call is on Rose Lane, assignment #1 goes to fill sick call and offer overtime from 0600 - 1400 for Rose Lane.
• If sick call is bath shift, RN will ask for a volunteer to change assignments.
• If no volunteers, assignment #1 becomes bath shift and offer overtime from 0600 - 1400 for Rose Lane."

If two PSWs short: "Utilizing the call in process, offer straight time to PSWs including any FT PSWs who are working less than 10 shifts in current pay period. If no one accepts straight time:
• Re-assign bath shift to home area with only one PSW.

• If one of the sick calls is on Rose Lane, offer overtime from 0600 – 1400.
• If sick calls are on Rose Lane, assignment #1 goes to the sick call and offer overtime from 0600 - 1100 for Rose Lane.
• Offer overtime from 0600 - 1100 for bath shift (or adjust the 5 hours as necessary for 1400 - 2200 shift).
• If no one accepts overtime for the bath shift, PSW must complete bed baths and document.
• Contact on-call manager and at direction, contact agency for PSW coverage."

For the 1400 – 2200 hours shift, there should be seven PSWs for three home areas and one PSW for bathing scheduled.
If one PSW short: "Utilizing the call in process, offer straight time to PSWs including any FT PSWs who are working less than 10 shifts in current pay period. If no one accepts straight time:
• Offer a full 1400 - 2200 shift to the 1500-2100 (bath) assignment.
• Offer 3 hours of overtime for the bath shift.
• If 1500 – 2100 (bath) person cannot extend the shift to 1400 – 2200, then offer 4 hours for bath shift and 1500 – 2100 person will work in the area of the sick call."

If two PSWs short: "Utilizing the call in process, offer straight time to PSWs including any FT PSWs who are working less than 10 shifts in current pay period. If no one accepts straight time:
• Offer a full 1400 - 2200 shift to the 1500-2100 (bath) assignment.
• Offer overtime from 1700 – 2200 (or adjust the 5 hours as necessary for the 0600 – 1400 shift).
• Offer 3 hours of overtime for the bath shift.
• If 1500 – 2100 (bath) person cannot extend the shift to 1400 – 2200, then offer 4 hours for bath shift and 1500 – 2100 person will work in the area of the sick call."

For the 2200 – 0600 hours shift, there should be one PSW on each home area scheduled.
If one PSW short "Utilizing the call in process, offer straight time to PSWs including any FT PSWs who are working less than 10 shifts in current pay period. If no one accepts straight time:
• Offer overtime to PSWs.

• If no one accepts overtime, each PSW covers one and half home area.
• Registered staff on duty to assist PSWs as they are able."

On September 11, 2019, in an interview, ED #100 stated the home had just revamped their contingency plan and job descriptions for Personal Support Workers (PSWs). ED #100 stated the contingency plan had been reviewed by the registered staff. ED #100 stated they had told the registered staff that they had to lead and if the home was short staffed, registered staff needed to think of what they needed to do to assist.

A) In an interview, resident #004 stated they had missed their bath on a specific day as there were not enough staff working that day. Resident #004 stated they had not yet been offered a bath in place of the bath they had missed.

Two days later, resident #004 told inspector they were going down to have a bath as it was their normal bath day. Resident #004 stated they never received a bath to make up for the bath they missed.

Review of documentation from Point of Care (POC) for a specific date, noted resident #004 did not receive a bath as they had indicated.

Review of the daily roster noted that on the day resident #004 had missed their bath, there were two partially unfilled PSW shifts from 0600 – 1000 hours, an unfilled shift from 0600 – 1400 hours and two partially unfilled shifts from 1400 – 1800 hours.

In an interview, Personal Support Worker (PSW) #113 stated that they were the full time bath person from 0600 to 1400 hours. PSW #113 stated there was an afternoon bath person who worked 1400 to 2000 hours, and the floor PSWs on evenings were also scheduled some baths. PSW #113 stated on days when the home was two PSWs short they were pulled to help with resident care on the area that was short. PSW #113 stated there were times when afternoon staff would come in earlier at 1000 hours and then PSW #113 would return to baths and try to complete about four baths before the end of their shift. PSW #113 stated that this occurred a lot on the weekend, but they were now working short during the week.

PSW #113 stated when they were pulled to work on the floor, they were to offer baths to the residents who missed baths on their next shift. PSW #113 stated they had a hard time trying to pick up the baths that were missed and before they knew it, they had completed the second scheduled bath of the week for a resident and they had not made up the bath that was missed.

In an interview, PSW #114 stated on August 10, 2019, they started to keep a log of shifts that were short. PSW #114 stated to date there were 25 day and afternoon shifts that were short PSWs. PSW #114 stated staff would come in and work 12 hour shifts to cover part of a shift and to give the residents the care they deserved.

PSW #114 stated some days the home was short a PSW from 0600 to 1000 hours or a full shift from 0600 to 1400 hours. PSW #114 stated there were times the home was two or three PSWs short and afternoon PSWs came in at 1000 hours and worked 1000 to 2200 hours. PSW #114 stated staff could not catch up on what was missed, and ultimately baths were missed.

In an interview, PSW #102 stated that they were working short. PSW #102 stated that they were scheduled to work Rose Lane but because they were short a PSW they were pulled to work on Lilac Lane. PSW #102 stated that normally there were three PSWs scheduled for Rose Lane as there were more residents on that home area, there were two PSWs for Lilac Lane and two for Lily Lane and a bath person on day shift. PSW #102 stated when they were one PSW short a PSW was pulled from Rose Lane and they worked two PSWs on each home area. PSW #102 stated when there were two PSWs short the bath person was then pulled, and they worked two PSWs on each home area.

PSW #102 stated they had worked a recent weekend and had worked short PSW staff on both days. PSW #102 stated there were five PSWs working on the Sunday and six on the Saturday, when there should be a total of eight PSW staff.

PSW #102 stated on the Saturday, they were short a bath PSW and one PSW on the floor until 1000 hours, when two afternoon PSWs came in early. On the Sunday, PSW #102 stated there were five PSWs total, one PSW was on Lily by themselves, two PSWs were on Rose and two PSWs were on Lilac and there

was no bath PSW. PSW #102 stated two PSWs came in at 1000 hours, leaving one PSW short on the floor. PSW #102 stated that on the weekend housekeeping and activation staff had helped porter residents.

PSW #102 stated they often worked short on weekends but lately they were working short during the week. PSW #102 stated at times they found it was hard getting resident care done on time for breakfast and to get everyone toileted after breakfast was sometimes impossible.

In an interview, PSW #103 stated that they had come in early and were working 1000 to 2200 hours, as Rose Lane was short a PSW from 0600 to 1400 hours. PSW #103 stated summer students had gone back to school which had caused the home to be short staffed on the weekends and during the week. PSW #103 stated baths were getting missed when they were working short.

Review of the home's bath schedule noted ten residents were scheduled daily for the 0600 – 1400 hour bath shift, eight residents were scheduled daily for the 1400 – 2000 hour bath shift and approximately four residents daily to be bathed by the evening floor PSW assigned to the resident.

The bath binder at the nurses' station was reviewed and noted a memo dated October 25, 2018, which stated in part, if a bath was missed, that the resident should be offered a bath on the next shift/day. All missed baths should be brought forward and completed before the next shifts/days bath.

Review of the communication notes in the bath binder from July 1, 2019 to September 12, 2019, noted 92 out of 269 (34.2%) baths were missed.

In an interview, Director of Care (DOC) #101 reviewed communication of missed baths in bath binder. DOC #101 acknowledged that residents had missed baths and that they had not been offered another bath. DOC #101 stated that if a resident missed a bath, they should be offered a bath the next day or a bed bath if the resident was agreeable. DOC #101 stated that sometimes the bath person would work later to get baths done and they themselves had assisted with baths. DOC #101 stated they needed to monitor missed baths better.

B) Review of resident #007's most recent care plan in Point Click Care noted

resident #007 required one person assistance with daily care.

On a specific date and time, resident #007 was observed seated outside the nurses' station in a chair. Resident #007 had a cup in their hand and was holding the cup upside down.

Inspector asked resident #007 if they needed assistance. Resident #007 gave inspector their cup and inspector noted that resident #007's lap and pants were wet from the spilled drink.

Inspector saw Personal Support Worker (PSW) #105 in the hallway handing out snacks. Inspector informed PSW #105 that resident #007 had spilled their drink on their pants and their pants were soaked. PSW #105 stated that they had just given resident #007 the drink. Inspector asked PSW #105 if they could assist resident #007 get out of their wet clothes and PSW #104 stated they would assist resident #007. PSW #105 then went into a resident's room with a snack.

Approximately 35 minutes later, Inspector returned to the floor and observed resident #007 in their room. Resident #007 was lying in bed on top of the covers. Inspector observed that resident #007 was still wearing their wet pants.

Inspector approached PSW #106 who was in the hallway. PSW #106 stated they were unable to speak with inspector as they were going in to check on resident #007.

A review of the home's daily roster noted on the specific date, the 0600-1400 shift was short a PSW from 0600-1000 hours.

In an interview, Director of Care (DOC) #101 stated when Inspector #522 informed PSW #105 that resident #007 was wet, PSW #105 should have assisted resident #007 right away. DOC #101 stated no one liked to be wet, and staff should never leave a resident wet. DOC #101 stated they would follow up with the PSW.

In an interview, PSW #106 stated that they were assigned to care for resident #007 on the specific date. PSW #106 stated that they were working short that shift. PSW #106 stated that PSW #105 did not make them aware that resident

#007 was wet and needed to be changed until PSW #105 had seen Inspector #522 come out of resident #007's room. PSW #106 stated once they were aware the resident needed changed, they went and provided care to the resident. PSW #106 stated they had come in early and were working 1000 to 2200 hours, as the home was short a PSW. PSW #106 stated when they worked short staff tried to help each other as much as they could.

C) Resident #001's care plan noted that resident #001 was incontinent and required extensive assistance.

Review of resident #001's electronic kardex on PCC noted the resident was to be repositioned every two hours.

On a specific date, resident #001 was observed seated in at a table in the dining room for approximately three and a half hours, during which time inspector noted a faint odour of urine from resident #001.

Just before shift change, PSW #103 removed resident #001 from the dining room and wheeled resident #001 into their room.

In an interview, PSW #103 stated they were assigned resident #001 that day. PSW #103 acknowledged that resident #001 had been seated in the dining room since the morning and that they had not had time to provide continence care to resident #001 until they removed the resident from the dining room before shift change. PSW #103 stated that they had come in early and were working 1000 to 2200 hours, as they were short a PSW from 0600 to 1400 hours.

The following day, resident #001 was observed seated at a table in the dining room eating breakfast. During a continuous observation of approximately one and a half hours, resident #001 was not brought back to their room to have continence care provided or to be repositioned. Resident #001 remained seated at the same table and as staff were observed serving lunch, resident #001 was noted to be sleeping, with their head hanging down with their hair hanging in their face.

Just before shift change, resident #001 was observed in their room lying in bed

sleeping. Inspector spoke with PSW #114 who stated that they had just put resident #001 into bed.

The following day, resident #001 was observed seated at a table in the dining room having breakfast. Inspector observed that resident #001 was not brought back to their room prior to lunch to have continence care provided or to be repositioned. Just before shift change, resident #001 was observed sleeping in their bed.

In an interview, PSW #112 stated they were assigned resident #001 and they had put resident #001 to bed approximately twenty minutes earlier. PSW #112 stated they were working short and they did not normally care for resident #001. Inspector asked if it was normal for resident #001 to be up before breakfast until just before shift change, without being repositioned or continence care provided. PSW #112 asked PSW #108 if it was normal for resident #001 to still be up at this time. PSW #108 stated sometimes resident #001 did not get put back to bed until after 1400 hours, after the afternoon staff started their shift. Inspector asked if staff brought resident #001 back to their room during the day to provide continence care. PSW #112 and PSW #108 stated that they did not have time to do that and that resident #001 did not have continence care provided until they were put to bed in the afternoon. Inspector asked if the staff repositioned resident #001 when they were up. PSW #112 and PSW #108 stated they would look at resident #001 to see if they were tilted and they would adjust them if needed, but that would only be if they noticed resident #001 was leaning to one side. PSW #112 and PSW #108 stated that they were short staffed and did not have the time to provide continence care to resident #001 after they were up in their chair until resident #001 was put to bed in the afternoon.

A review of the home's daily roster noted the following unfilled or partially unfilled shifts on the days resident #001 was observed.

Day one of observations, 0600-1400 shift was short a PSW from 0600-1000 hours.
Day two of observations, 0600-1400 shift was short a PSW from 0600-1000 hours.
Day three of observations, 0600-1400 shift was short a PSW from 0600-1400 hours and 0600-1000 hours.

Review of resident #001's electronic documentation in Point of Care (POC) from July 1 to September 12, 2019, noted the absence of documentation on the following shifts:

Continence Assistance:
July
Days - 9 out of 31 shifts (29%).
Evenings - 1 out of 31 shifts (3%)
Night - 1 out of 31 shifts (3%)

August
Days - 15 out of 31 shifts (48.3%).
Evenings - 5 out of 31 shifts (16.1%).
Night - 4 out 31 shifts. (12.9%).

September
Days - 7 out of 12 shifts (58.3%)
Evenings - 1 out of 12 shifts (0.8%).

Daily care needs:
July - 16 out of 31 day shifts (51.6%).
August - 20 out 31 day shifts (64.5%).
September - 9 out of 12 day shifts (75%).

Evening care needs:
July - 9 out of 31 evening shifts. (29%).
August - 8 out of 31 evening shifts (25.8%).
September - 2 out of 12 evening shifts (16.6%).

Night care needs:
July - 9 out of 31 night shifts. (29%).
August - 4 out of 31 night shifts (12.9%).
September -2 out of 12 night shifts (16.6%).

Turning and positioning:
July

Days - 16 out of 31 shifts (51.6%).
Evenings - 5 out of 31 shifts (16%).
Nights - 2 out of 31 shifts (6.4%).

August
Days - 21 out of 31 shifts (67.7%).
Evenings - Nine out of 31 shifts (29%).
Nights - Four out of 31 shifts (12.9%).

September
Days - 9 out of 12 shifts (75%).
Evenings - 3 out of 12 shifts (25%).
Nights - 2 out of 12 shifts (16.6%).

In an interview, Director of Care (DOC) #101 stated resident's who were incontinent should have continence care provided at a minimum three times during the day, with morning care, after breakfast, and after lunch. DOC #101 stated residents should also have continence care provided after supper and then at bed time and then a minimum of twice during the night shift.

DOC #101 stated that it was unacceptable that resident #001 had not had continence care provided from when they were up in the morning until just before shift change. DOC #101 stated the only reason staff would not provide continence care to a resident was if the resident refused, then staff would need to leave and reapproach the resident.

In an interview, DOC #101 acknowledged that charting on POC was not being completed for resident #001. DOC #101 stated staff should be charting that they took care of the resident's needs through each shift and staff should be charting on POC after care was provided.

D) Review of resident #002's electronic care plan on Point Click Care noted resident #002 required assistance with daily care.

The care plan noted that resident #002 was incontinent and required extensive assistance.

On a specific date, resident #002 was observed in their room after breakfast had started.

In an interview, PSW #109 stated that resident #002 had come down to the dining room at about 30 minutes after breakfast had started. Inspector asked if that was common for the resident to come down that late. PSW #109 stated that it was common for resident #002 to come down late for breakfast when they were working short and they were short one PSW that day.

The following day resident #002 was observed seated in the dining room, the resident was not dressed appropriately for the time of day.

Prior to lunch, resident #002 was observed dressed the same. A faint odour of urine was noted from the resident.

Twenty-five minutes after lunch had started, PSW #116 was observed taking resident #002 to the dining room for lunch. Residents were already in the dining room eating their meal.

In an interview, PSW #116 stated they were assigned to resident #002 today as they were working short. PSW #116 stated they had taken resident #002 down for lunch late. PSW #116 stated when they went to get resident #002 for lunch, they had to put resident #002 back to bed to provide continence care. Inspector asked if it was normal for resident #002 to be up before breakfast and then put back to bed in the afternoon. PSW #116 stated they did not know resident #002's routine. Inspector asked if resident #002 had been put back to bed after breakfast to have continence care provided. PSW #116 stated resident #002 did not have continence care provided after breakfast. PSW #116 stated they did not have time to get resident #002 up then put them to bed and get them up again for lunch. PSW #116 stated they only provided continence care to resident #002 before lunch because resident #002 was observed to need continence care.

Review of Point of Care (POC) documentation noted staff documented that resident #002 did not receive a bath as scheduled on a specific date.

A review of the home's daily roster noted the following unfilled or partially unfilled

shifts:

The day resident #002 missed their bath, the 0600-1400 shift was short a PSW from 0600-1000 hours.
The first day of observations of resident #002, the 0600-1400 shift was short a PSW from 0600-1000 hours.
The second day of observations of resident #002, the 0600-1400 shift was short a PSW from 0600-1400 hours and 0600-1000 hours.

Review of resident #002's electronic documentation in POC from July 1 to September 12, 2019, noted the absence of documentation on the following shifts:

Continence Assistance:
September – 7 out of 12 days (58.3%) and 3 out of 12 evenings (25%)

August
Days - 12 out of 27 (44.4%)
Evenings - 8 out of 27 (29.6%)
Nights - 2 out of 27 (7.4%)

Daily care needs:
September - 10 out of 12 shifts (83.3%)
August - 20 out of 27 shifts (74%)

Evening care needs:
September - 4 out of 12 shifts (33.3%)
August - 14 out of 27 shifts (51.8%)

Night care needs:
September - 5 out of 12 shifts (41.6%)
August - 11 out of 27 shifts (40.7%)

Bathing: August - 2 out of 8 baths (25%)

In an interview, DOC #101 stated that it was unacceptable that resident #002 had not had continence care provided from when they were up in the morning

until just before lunch. DOC #101 stated that breakfast was served from 0830 to 0930 hours and lunch was served from 1200 to 1300 hours and staff should have had residents down for their meal approximately 15 minutes prior to the start of the meal. DOC #101 stated that resident #002 should be brought down to meals on time and should be dressed appropriately.

DOC #101 acknowledged that charting on POC was not being completed for resident #002. DOC #101 stated staff should be charting that they took care of the resident's needs through each shift and staff should be charting on POC after care was provided.

E) Review of resident #003's most recent electronic plan of care on PCC noted that resident #002 required assistance with daily care.

The care plan noted that resident #003 was incontinent.

Review of the bath book communication noted resident #003 did not receive a bath as scheduled on a specific day. Documentation beside resident #003's name noted staff worked short that day.

Review of the home's daily roster noted on the day resident #003 missed their bath, the 1400 - 2200 shift was short two PSWs.

Review of resident #003's electronic documentation in Point of Care (POC) from July 1 to September 12, 2019, noted the absence of documentation on the following shifts:

Continence Assistance:

September
Days - 8 out of 12 shifts (66.6%)
Evenings - 3 out of 12 shifts (25%)

August
Days: 15 out of 31 shifts (48.3%)
Evenings: 7 out of 31 shifts (22.5%)
Nights: 2 out of 31 shifts (6.4%)

July
Days: 11 out of 31 shifts (35.4%)
Evenings: 2 out of 31 shifts (6.4%)
Nights: 1 out of 31 shifts (3.2%)

Continence Intervention:
September
Evenings: 9 out of 12 shifts (75%)
Nights: 2 out of 12 shifts (16.6%)

August
Days: 18 out of 31 shifts (58%)
Evenings: 7 out of 31 shifts (22.5%)
Nights: 1 out of 31 shifts (3.2%)

July
Days: 13 out of 31 shifts (41.9%)
Evenings: 2 out of 31 shifts (6.4%)

Daily care needs:
September - 11 out of 12 shifts (91.6%)
August – 16 out 31 shifts (51.6%)
July – 13 out of 31 shifts (41.9%)

Evening care needs:
September - 8 out of 12 shifts (66.6%)
August – 10 out of 31 shifts (32.2%)
July – 7 out of 31 shifts (22.5%)

Night care needs:
September - 7 out of 12 shifts (58.3%)
August – 2 out of 31 shifts (6.4%)
July – 2 out of 31 shifts (6.4%)

Turning and positioning:

September
11 out of 12 days at 0600, 0800, 1000, and 1200 hours (91.6%)
5 out of 12 days at 1400 hours (41.6%)
6 out of 12 days at 1600 hours (50%)
8 out of 12 days at 1800 and 2000 hours (66.6%)
1 out of 12 night shifts (8.3%)

August
2 out of 31 days at 0000, 0200, and 0400 hours (6.4%)
10 out of 31 days at 0600, 0800, 1000 hours (32.2%)
1 out of 31 days at 1000 hours (3.2%)
13 out of 31 days at 1200 hours (41.9%)
3 out of 31 days at 1400 hours (9.6%)
5 out of 31 days at 1600 hours (16.1%)
6 out of 31 days at 1800hours (19.3%)
5 out of 31 days at 2000 hours (16.1%)
2 out of 31 night shifts (6.4%)

July
13 out of 31 days at 0600 and 0800 hours (41.9%)
13 out of 31 days at 1000 hours (41.9%)
14 out of 31 days at 1200 hours (45.1%)
4 out of 31 days at 1400 and 1600 hours (12.9%)
5 out of 31 days at 1800 and 2000 hours (16.1%)
1 out of 31 night shifts (3.2%)

August 2019 – Bathing: 1 out of 9 baths (11%)

In an interview DOC #101 acknowledged that charting on POC was not being completed for resident #003. DOC #101 stated staff should be charting that they took care of resident #003's needs through each shift. DOC #101 stated that staff should be charting on POC after care was provided.

F) On September 11, 2019 at 0915 hours, Personal Support Worker (PSW) #108 was observed taking a resident to the dining room. PSW #108 stated the resident was just going down for breakfast. PSW #108 stated some residents were brought down for breakfast now because they were working short.

On September 12, 2019 at 0900 hours, PSW #108 stated they still had two residents to get up for breakfast.

Observations at approximately 0915 hours, noted several residents were still in bed. PSW #116 stated that they were working two staff short and they had to pull the bath person to help so there would be no baths today. PSW #117 stated they still had three residents that were in bed and needed to get up for breakfast. PSWs #116 and #117 were working together to get the residents up.

At approximately 1147 hours, PSW #116 stated a PSW came in at 1000 hours, and they were only one PSW short at that time.

A review of the home's daily roster noted the following unfilled or partially unfilled shifts:

September 11, 2019, 0600-1400 shift was short a PSW from 0600-1000 hours.
September 12, 2019, 0600-1400 shift was short a PSW from 0600-1400 hours and 0600-1000 hours.

Observations on September 11 and 12, 2019, noted Director of Support Services (DSS) #111 answering resident call bells. The Office Manager and recreation staff were also observed portering residents to the dining room and back to their room after meals.

In an interview, DSS #111 stated if they were on a wing and a resident's call bell was on, they would answer the call bell. DSS #111 stated if it was something they could help with they would assist the resident but if a resident needed personal care, they would let staff know.

DSS #111 stated in each department the home tried to cross train staff in different areas, that way if PSW staff were short on a shift they could call people in to porter residents or to come in early to assist with beds.

In an interview, DOC #101 stated that breakfast was served from 0830 to 0930 hours, and lunch was served from 1200 to 1300 hours. DOC #101 stated staff should have residents down for their meal approximately 15 minutes prior to the

start of the meal. DOC #101 stated when staff were working short recreation staff, housekeeping staff and managers would help to porter residents, assist residents with dining and if staff were trained, they would help feed residents.

G) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to an incident of resident to resident abuse.

Review of the CIS report noted a Personal Support Worker (PSW) had observed the incident between resident #010 and resident #009.

Review of risk management on Point Click Care related to the incident noted that the incident occurred when the Registered Nurse was on break and the PSWs had reported the incident to the Registered Practical Nurse (RPN) on the floor.

Review of the CIS report provided by Director of Care (DOC) #101 noted a hand written account of the incident from PSW #112 and PSW #114. At the bottom of the note it stated, "PSW working 3 short."

A review of the home's daily roster for the date the incident occurred, noted there were two unfilled shifts and the bath shift was unfilled for two hours. Two agency Registered Practical Nurses (RPNs) were working with the Registered Nurse.

In an interview, Personal Support Worker (PSW) #112 stated that they had found resident #010 and #009. PSW #112 stated they were working short that shift and the PSW assigned to the home area where resident #010 resided, was on break. PSW #112 stated the registered staff working was covering the home area while the PSW was on break, which was part of the home's contingency plan.

In an interview, Director of Care (DOC) #101 was asked if they had considered that staffing levels might have contributed to resident #010 wandering from their room at the end of one home area, which was short two staff, to resident #009's room which was at the end of another home area. DOC #101 stated that they had not considered staffing levels as a contributing factor and that there were two PSWs and a RPN on the floor when the incident occurred.

H) A review of the home's staffing schedule provided by Scheduling Coordinator #107 noted the following unfilled staff lines:

Two Registered Nurse (RN) lines - Two nights in a two week period and four nights in a two week period.
One Registered Practical Nurse (RPN) line – Two days in a two week period.
Five Personal Support Worker (PSW) lines:
Line 8 – Permanent Part Time 15 hours - Two days in a two week period (Saturday and Sunday).
Line 11 - Four days in a two week period (Saturday, Sunday, Friday, and Tuesday).
Line 12 - Two evenings in a two week period (Saturday and Sunday).
Line 13 - Two evenings in a two week period (Saturday and Sunday).
Line 15 - Four evenings in a two week period (Saturday, Sunday, Friday, and Tuesday).

Review of the home's Daily Roster from July 1 to September 15, 2019, noted the following:

One RN was scheduled 0700 -1500, 1500 - 2300 and 2300 - 0700 hours.
Two RPNs were scheduled 0700 - 1500 and 1500 - 2300 hours and one RPN 2300 - 0700 hours.
PSWs:
Days 0600 - 1400 hours - Three PSWs on Rose Lane, two on Lilac Lane, two on Lily Lane and one bath PSW.
Evenings – 1400 - 2200 hours- Three PSWs on Rose, two on Lilac, two on Lily and one bath PSW (1400 - 2000 or 1500 - 2100 hours).
Nights - 2200 - 0600 – Three PSWs, one on each wing.

The roster stated, "If there is a staffing shortage, please follow the contingency plan located in the front of the call-out binder."

Review of the daily roster of scheduled shifts from July 1 to September 15, 2019, noted the following full or partial unfilled PSW shifts:

July

0600 – 1000 hours – 7 shifts
0800 – 1400 hours – 1 shift
0830 – 1400 – 1 shift
0600 – 1400 – 2 shifts
1400 – 2200 – 6 shifts
1800 – 2200 – 2 shifts

August
0600 – 1000 – 11 shifts
0600 – 1030 – 1 shift
0600 – 1200 – 1 shift
0600 – 1400 – 5 shifts
1400 – 1800 – 1 shift
1400 – 2200 – 9 shifts
1600 – 2200 – 1 shift
1800 – 2200 – 1 shift
2200 – 0600 – 2 shifts
0200 – 0600 – 1 shift
Bath shift – 1800 – 2000 – 5 shifts
Bath shift – 0600 – 1000 – 1 shift

September
0600 – 1000 – 12 shifts
0600 – 1400 – 5 shifts
0900 – 1000 – 1 shift
1400 – 1800 – 5 shifts
1400 – 2200 – 1 shift
1800 – 2200 – 2 shifts
Bath shift – 0600 – 1400 – 2 shifts
Bath shift – 1700 – 2000 – 1 shift
Bath shift 1800 – 2200 – 1 shift

Review of the daily roster dated Sunday, August 25, 2019, noted there were two PSWs short from 0600 – 1000 hours. There were no notes on the bottom of the roster which indicated additional assistance from other departments during the shortage.

Review of the daily roster dated Saturday, August 31, 2019, noted there was a PSW short from 0600 – 1000 hours and a PSW short from 0600 - 1400 hours. There were no notes on the bottom of the roster which indicated additional assistance from other departments during the shortage.

Review of the daily roster dated Saturday, September 7, 2019, noted the 0600 – 1400 shift was short two PSWs from 0600-1000 hours. An evening PSW was scheduled to work 1000-2200 hours and another PSW was scheduled from 1000 – 1400 hours.
Another PSW 0600 – 1400 shift was short a PSW from 0900 - 1000 hours. The PSW scheduled the previous night stayed until 0900 hours and the evening PSW came in early and worked 1000-2200 hours.
There was no 0600-1400 bath PSW scheduled and the 1400-2200 shift was short a PSW from 1400-1800 hours.

A note on the bottom of the daily roster noted a program staff member was scheduled 0730 -1130 hours, to help with the PSW shortage, and a laundry staff member was scheduled at 0800 hours, to help porter residents and other laundry staff were to assist as well.

Review of the daily roster dated Saturday, September 14, 2019, noted the 0600 - 1400 shift was short two PSWs from 0600-1000 hours. Two evening PSWs were scheduled to come in early to work 1000 - 2200 hours. The bath PSW shift was short from 1700 - 2000 hours.

A note on the bottom of the daily roster indicated a laundry staff member was scheduled at 0900 hours, to help porter residents to and from the dining room. A program staff member was scheduled at 0830 hours, to help with breakfast and to porter residents.

In an interview, Scheduling Coordinator (SC) #107 stated the home had a contingency plan that they used for scheduling when they were short staffed. SC #107 stated that if there was one PSW short on days or evenings they would schedule two PSWs on each wing. If there were two PSWs short, then the bath PSW would be pulled to work on the floor and there would be two PSWs per wing.

SC #107 stated that they recently had seven nursing students return to school who had been taking a lot of the empty shifts over the summer. SC #107 stated there were seven empty PSW lines, one RPN and two RN lines, all of which were part time. SC #107 stated that for the PSW lines two were being filled by current staff and two or three new PSWs were starting and that would help with some of the empty lines. SC #107 stated the RN lines were filled by casual staff and they used agency staff as needed for the RPN line. SC #107 stated they had difficulty with agency PSWs and currently were not using agency PSW staff.

In an interview, SC #107 reviewed the daily roster from July 1 to September 15, 2019, with inspector and confirmed the unfilled and partially filled shifts. SC #107 stated when they had unfilled shifts, they tried to have a PSW come in early for a shift or stay later after their shift to help with coverage.

SC #107 stated every other Friday on the schedule was the worst to book as they started with eight unfilled shifts to fill. SC #107 stated on Saturday, September 14, 2019, program staff would come in to help to feed and porter residents and make beds.

SC #107 stated that although it was not documented on the roster, on Sunday, August 25, 2019, when the 0600 – 1400 hour shift was short two PSWs from 0600 – 1000 hours, they would have tried to get other staff to come in to assist and the Oncall Manager would have come in. SC #107 stated that DOC #101 came in that day to assist.

In an interview, Executive Director (ED) #100 stated every morning they had a risk management meeting and reviewed 24-hour report, staffing for the day and for the next week and the plan to cover shifts. ED #100 stated if baths were not completed on a shift, they were carried forward to the next shift. ED #100 stated the evening bath shift was not a full shift so if a bath was not completed in the morning they would try and have the evening person stay later or come in earlier. ED #100 stated they had identified earlier in the year that baths were not happening until the next bath cycle and addressed this with staff that this could not happen.

ED #100 stated that they were trying to hire to fill the vacant lines. ED #100

stated they did use agency staff to fill registered staff lines, but the home had not had success with using agency PSWs. ED #100 stated they were currently in the process of interviewing and hiring PSWs.

ED #100 stated when the home was working short PSWs they looked at who else was in the building – housekeeping, laundry, maintenance, office staff, management. ED #100 stated those staff could make a bed, porter residents and if trained, could assist with feeding. ED #100 stated they also extended shifts or had brought in staff from other departments to help with tasks when needed.

ED #100 stated they had recent retirements, terminations and had summer students return to school which had affected the staffing schedule. ED #100 stated they recently hired two new PSWs that started this week and they were checking references on three other PSW candidates.

ED #100 stated they knew the home did not always have enough staff, but the essentials were done and the residents were safe and happy.

In an interview, Director of Care (DOC) #100 acknowledged the number of unfilled and partially filled shifts. DOC #101 stated when the home was short staffed, they would put the contingency plan in place. DOC #101 stated if there was a shortage of PSWs they asked for help from other departments and managers would also assist. DOC #101 stated any staff could answer a call bell and if needed get the PSW. DOC #101 stated staff also helped to porter residents to meals when needed and managers would assist with feeding. DOC #101 stated they had also helped with baths when needed.

When asked by inspector if the current staffing level met the needs of residents, DOC #101 stated they believed staff provided the required care to residents, but that it was not reflected in the staff's documentation of the care provided. DOC #101 stated they felt staff were choosing to provide care over documentation.

Base on interviews, observations and record reviews the home has failed to ensure that the written staffing plan of the home met the care and safety needs of residents and promoted continuity of care related to regular PSW staff shortages.

The home had been operating on their contingency plan several times per week for 10 weeks. From September 3 to 15, 2019, the home had been operating on their contingency plan daily. During this time, residents did not receive two baths per week, and observations noted residents did not receive continence care, turning and repositioning, were not brought down for meals on time, and documentation was not completed.

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

The severity of this issue was determined to be a level 3 as there was actual risk to the residents. The scope of the issue was a level 3 as it was widespread. The home had a level 3 history of noncompliance with this section of Ontario Regulation 79/10, that included a Voluntary Plan of Correction (VPC) issued November 22, 2018 (2018_722630_0024). (522)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 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 2nd day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Lampman

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