Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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 sions de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
May 24, 2016;	2016_320612_0010 (A1)	000979-16	Follow up

Licensee/Titulaire de permis

THE CITY OF GREATER SUDBURY
200 Brady Street PO Box 5000 Stn A SUDBURY ON P3A 5P3

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

PIONEER MANOR
960 NOTRE DAME AVENUE SUDBURY ON P3A 2T4

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

SARAH CHARETTE (612) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Licensee requested an extension for compliance order (CO) #003 from July 29, 2016 to September 06, 2016.

Issued on this 24 day of May 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

SARAH CHARETTE (612) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 4-8, and 11, 2016.

This Follow Up Inspection is related to (Log #004663-16) immediate investigation of alleged, suspected or witnessed incidents of abuse (compliance order (CO) #001), and the annual evaluation of the home's abuse program (CO#002); (Log #000979-16) the duty to protect residents from abuse and neglect (CO #001), the home's abuse policy (CO#002) and insufficient staffing (CO #005); (Log #000982-16) immediate reporting (#003), complying with the home's skin and wound, responsive behaviour and medication policies (#004), managing responsive behaviours (#006), and the residents' plan of care (CO#008 and #009).

A Critical Incident Inspection #2016_320612_0009, and Complaint Inspection #2016_282543_0011 were conducted concurrently to this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care (MRC), Program Coordinators (PCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Manager of Physical Services, Laundry Housekeeping and Material Control Services Manager, Scheduling Coordinator, Manager of Administration, Housekeepers, and residents and their family members.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to resident interactions,

reviewed residents' health care records, staffing schedules, staff training records, policies, procedures, programs, and annual program evaluation records.

The following Inspection Protocols were used during this inspection:

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 23. (1)	CO #001	2016_336620_0004	612
LTCHA, 2007 s. 24. (1)	CO #003	2015_391603_0029	612
LTCHA, 2007 s. 6. (7)	CO #008	2015_391603_0029	612
O.Reg 79/10 s. 99.	CO #002	2016_336620_0004	612

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A previous compliance order (CO) #009 was issued on January 8, 2016, to address the licensee's failure to comply with s. 6. (1) (c) of the LTCHA, 2007 during Resident Quality Inspection (RQI) #2015_391603_0029(A1).

The CO required the licensee to prepare, submit, and implement a plan to ensure that there was a plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident. The plan was to include:

i) Education and retraining for all staff involved in developing residents' written plans of care, including the risks associated with the lack of clear directions to staff and others who provided direct care to the residents.

The compliance plan was to be submitted by January 22, 2016, with full compliance by February 5, 2016.

In an interview with the Manager of Resident Care (MRC), they stated that additional online training modules were added for the year 2016, one titled "Resident Care Plans- Updating of"; the other titled "Point of Care Documentation".

The Inspector reviewed the training records which indicated that 42 per cent of staff had not completed the "Resident Care Plans- Updating of" training and 47 per cent of staff had not completed the "Point of Care Documentation" training.

The MRC and the Administrator stated in an interview that an 'interoffice correspondence' was distributed to all staff who had access to e-mail which provided a new process for reviewing residents plans of care based on the orders from RQI #2015_391603_0029(A1). The 'interoffice correspondence' was posted in all units, and was accessible by all staff. The Administrator stated it was the staff's responsibility to read the 'interoffice correspondence'. The Administrator was unable to confirm if 100 per cent of staff had reviewed it. Although all staff were required to read the 'interoffice correspondence', the Administrator stated that it was not a replacement for the training.

The MRC and the Administrator of the home stated that they had allowed staff until December 1, 2016, to complete the training and that there was a disciplinary process

in place if staff had not completed the training by then. The MRC confirmed that not all staff had completed the training by the compliance date of February 5, 2016. [s. 6. (1) (c)]

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

A complaint was received by the Director, related to resident #006 having had multiple falls.

Inspector #543 reviewed the home's Risk Management documentation related to the resident's falls between a specific time frame, and identified that the resident had experienced multiple falls.

On a specific date, resident #006 fell and sustained an injury.

The Inspector reviewed the resident's plan of care in place at the time of the fall, as well as their most recent plan of care, specifically related to falls. Both plans identified that resident #006 was at moderate risk for falls, and there were specific interventions related to falls prevention.

The Inspector reviewed the resident's post fall incident report (Post Fall Assessment) from the fall that occurred on a specific date. The report indicated that the specific intervention listed in resident #006's plan of care was not implemented.

No further action will be taken in regards to this non-compliance as the incident occurred prior to the compliance date for CO #008 which was February 5, 2016, from inspection #2015_391603_0029(A1). [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A previous CO #001 was issued on January 8, 2016, to address the licensee's failure to comply with s. 19(1) of the LTCHA, 2007 during RQI #2015_391603_0029(A1).

The CO required the licensee to prepare, submit, and implement a plan for achieving compliance with the LTCHA, 2007, s. 19(1). The plan was to include:

i) What steps the licensee would take to ensure that all residents in the home were protected from abuse and/or neglect by the staff, including training on the home's abuse policies, training related to the management of responsive behaviours, and training related to the requirements to provide care to all residents, as identified in their plan of care.

The compliance plan was to be submitted by January 22, 2016, with full compliance by February 5, 2016.

Inspector #612 requested training records related to the, "Resident Abuse/Neglect policy". The Inspector noted that the title of the policy had changed to "Promoting Zero Tolerance of Abuse and Neglect of Residents". The MRC stated that the test at the end of the presentation had changed; staff were now required to achieve a grade of 100 per cent to complete the training.

In an interview, the MRC confirmed that 49 per cent of the staff had not completed the training titled "Promoting Zero Tolerance of Abuse/Neglect of Residents".

The Inspector reviewed the additional training records provided by the MRC and noted that 44 per cent of staff had not completed the training related to the "Responsive

Behaviours" Program and 62 per cent of registered staff had not completed the "Managing Responsive Behaviours" training.

Additional training records were provided by the MRC related to "Resident Care Plans- Updating of", which 42 per cent of staff had not completed and "Point of Care Documentation", which 47 per cent of the PSW’s had not completed.

The MRC and the Administrator stated in an interview that an ‘interoffice correspondence’ was distributed to all staff who had access to e-mail to update them on the policy changes as well as changes made based on the compliance orders from RQI #2015_391603_0029(A1). The ‘interoffice correspondence’ was posted in all units, and was accessible by all staff. The Administrator of the home stated it was the staff’s responsibility to read the ‘interoffice correspondence’. The Administrator was unable to confirm if 100 per cent of staff had reviewed it. Although all staff were required to read the 'interoffice correspondence', the Administrator stated that it was not a replacement for the training.

The MRC and the Administrator of the home stated that they had allowed staff until December 1, 2016, to complete the training and that there was a disciplinary process in place if staff had not completed the training by then. The MRC confirmed that not all staff had completed the training by the compliance date of February 5, 2016. [s. 19. (1)]

2. The licensee has failed to protect resident #016 from abuse by resident #001.

Inspector #543 reviewed a Critical Incident (CI) report related to an incident of alleged resident to resident abuse. According to the CI, both residents involved in the incident resided on a secure unit. Housekeeper #126 witnessed the incident between resident #001 and #016. Resident #016 sustained an injury as a result of the incident.

O. Reg 79/10 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

The Inspector reviewed a summary of resident #001’s responsive behaviours provided by the home. The resident exhibited physically responsive behaviours towards staff and then towards another resident; therefore, one to one staffing was implemented. The resident continued to exhibit physically responsive behaviours towards staff, specifically during personal care and towards other residents.

During a meeting between Program Coordinator (PC) #103, RPN #101, and the Manager of Resident Care (MRC), they identified that the bulk of the incidents of physically responsive behaviour were towards staff. The decision was made for two staff to provide care to the resident and the one to one staffing was stopped. There were no interventions implemented to protect other residents on the unit from resident #001.

Resident #001 had three incidents of physically responsive behaviours towards other residents between the time that the one to one was stopped and the incident between resident #001 and #016.

The Inspector interviewed housekeeper #126 who confirmed that they witnessed the incident as described in the CI, between residents #001 and #016.

On April 11, 2016, the Inspector spoke with PC #103 who confirmed the incident as described in the CI. PC #103 stated that a result of that incident one to one staffing was re-initiated for resident #001 and had remained in place since.

No further action will be taken in regards to this non-compliance as the incident occurred prior to the compliance date for CO #001 which was February 5, 2016, from inspection #2015_391603_0029(A1). [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A previous CO #002 was issued on January 8, 2016, to address the licensee's failure to comply with s. 20(1) of the LTCHA, 2007 during the RQI #2015_391603_0029(A1).

The CO required the licensee to prepare, submit, and implement a plan for achieving compliance with the LTCHA, 2007, s. 20(1). The plan was to include:

i) Steps the licensee will take to ensure that all staff, including management staff, received retraining on the home's current policy Resident Abuse/Neglect.

The compliance plan was to be submitted by January 22, 2016, with full compliance by February 5, 2016.

Inspector #612 requested training records related to the, "Resident Abuse/Neglect policy". The Inspector noted that the title of the policy had changed to, "Promoting Zero Tolerance of Abuse and Neglect of Residents". The MRC stated that the test at the end of the presentation had changed and staff were now required to achieve a grade of 100 per cent to complete the training.

In an interview, the MRC confirmed that 49 per cent of staff had not completed the training titled, "Promoting Zero Tolerance of Abuse/Neglect of Residents".

The MRC and the Administrator stated in an interview that an 'interoffice correspondence' was distributed to all staff who had access to e-mail to update them on the policy changes; as well as, changes made based on the compliance orders from RQI #2015_391603_0029(A1). The 'interoffice correspondence' was posted in all units, and was accessible by all staff. The Administrator of the home stated it was the staff's responsibility to read the 'interoffice correspondence'. The Administrator was unable to confirm if 100 per cent of staff had reviewed it. Although all staff were required to read the 'interoffice correspondence', the Administrator stated that it was not a replacement for the training.

The MRC and the Administrator of the home stated that they had allowed staff until December 1, 2016, to complete the training and that there was a disciplinary process in place if staff had not completed the training by then. The MRC confirmed that not all staff had completed the training by the compliance date of February 5, 2016. [s. 20. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A previous CO #006 was issued January 8, 2016, to address the licensee’s failure to comply with s. 54 of O. Reg. 79/10 during the RQI #2015_391603_0029(A1).

The CO required the licensee to ensure that:

i) Training was provided to all direct care staff related to the “Responsive Behaviours Prevention, Assessment and Management of” and Resident Care, “Documentation Shift to Shift Report” policies.

The Inspector reviewed the training records provided by the MRC and noted that 44 per cent of staff had not completed the training related to the "Responsive Behaviours" program and 62 per cent of registered staff had not completed the "Managing Responsive Behaviours" training.

The MRC and the Administrator stated in an interview that an ‘interoffice correspondence’ was distributed to all staff who had access to e-mail to update them on the policy changes; as well as, changes made based on the compliance orders from RQI #2015_391603_0029(A1). The ‘interoffice correspondence’ was posted in all units, and was accessible by all staff. The Administrator of the home stated it was the staff’s responsibility to read the ‘interoffice correspondence’. The Administrator was unable to confirm if 100 per cent of staff had reviewed it. Although all staff were required to read the 'interoffice correspondence', the Administrator stated that it was not a replacement for the training.

The MRC and the Administrator of the home stated that they had allowed staff until December 1, 2016, to complete the training and that there was a disciplinary process in place if staff had not completed the training by then. The MRC confirmed that not all staff had completed the training by the compliance date of February 5, 2016. [s. 54. (b)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A previous CO #004 was issued on January 8, 2016, to address the licensee's failure to comply with s. 8. (1) (b) of O.Reg. 79/10 during the RQI #2015_391603_0029(A1).

The CO required the licensee to ensure that all staff and others who provided direct care to residents received training on the following policies:

i) "Skin Care (cross reference Skin Integrity- Preventive Assessment and Treatment)", last revised May 1, 2014, specifically that assigned PSWs were to complete a full resident head to toe assessment once per week and report all concerns to registered staff immediately and registered staff were to complete weekly wound assessment for all resident who had skin breakdown, according to policy.

ii) "Responsive Behaviours Prevention, Assessment and Management of", last revised December 5, 2014, specifically ensuring that if a resident demonstrated escalating, potentially injurious behaviours, DOC charting was initiated immediately and the resident was referred to BSO.

iii) "Medication Administration", last revised May 8, 2014, specifically ensuring the dignity and privacy of the resident was maintained and that eye/ear drops, inhalers, patches, g-tube or any type of injections were not to be administered in a public area, ie. dining room, nursing lounge, etc.

The compliance date of the order was February 5, 2016.

The Inspector reviewed the training records provided by the Manager of Resident Care (MRC):
- Skin and Wound care was completed over two modules, 60 per cent of staff had not completed module one and 61 per cent had not completed module two.
- The responsive behaviours training had not been completed by 44 per cent of staff.
- Medication administration had not been completed by 56 per cent of staff.

The MRC and the Administrator stated in an interview that an 'interoffice correspondence' was distributed to all staff who had access to e-mail to update them on the policy changes as well as changes made based on the compliance orders from RQI #2015_391603_0029(A1). The 'interoffice correspondence' was posted in all units, and was accessible by all staff. The Administrator of the home stated it was the staff's responsibility to read the 'interoffice correspondence'. The Administrator was unable to confirm if 100 per cent of staff had reviewed it. Although all staff were required to read the 'interoffice correspondence', the Administrator stated that it was not a replacement for the training.

The MRC and the Administrator of the home stated that they had allowed staff until December 1, 2016, to complete the training and that there was a disciplinary process in place if staff had not completed the training by then. The MRC confirmed that not all staff had completed the training by the compliance date of February 5, 2016. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A previous CO #005 was issued January 8, 2016, to address the licensee's failure to comply with s. 31 (3) of O.Reg. 79/10 during RQI Inspection #2015_391603_0029(A1).

The CO required the licensee to prepare, submit, and implement a plan to ensure that the staffing mix was consistent with residents' assessed care and safety needs, and that it met the requirements set out in the Act and this Regulation to achieve compliance with O. Reg. 79/10, s. 31(3). The plan was to include:

i) Steps the licensee would take to ensure that all residents received their preferred and scheduled baths that had been identified in their care plan.

The plan was due January 22, 2016, with full compliance expected by February 5, 2016.

During the course of the Follow-Up Inspection, Inspector #612 also inspected four complaints received by the Director related to staffing concerns within the home and that residents had not received their preferred bath as indicated in their care plan.

During an interview with the MRC and the Administrator, they stated that the staffing plan in the home had been reviewed and a plan was in place to ensure that residents received their preferred and scheduled baths. They stated that additional staff would be scheduled within 24-48 hours of a short shift and a PSW would be assigned to complete the missed baths.

The Inspector interviewed resident #023, #024 and #025. They all confirmed that in the few weeks prior to the current inspection, they had received bed baths or had not received a tub bath, as a result of the home being short.

The Inspector reviewed resident #023's documented care in Point of Care (POC). The resident had received a bed bath on two specific dates. A review of the resident's plan of care indicated that the resident's preference was a tub bath.

The Inspector reviewed resident #024's documented care in POC. The resident had received a bed bath on three specific dates. A review of the resident's plan of care indicated that the resident's preference was a tub bath.

The Inspector reviewed resident #025 documented care in POC. The resident received a bed bath on a specific date, and on another day, their bath was charted as 'not applicable'. The resident's plan of care indicated that the resident's preference was a tub bath.

The Inspector interviewed PSW #114, #115, and #118. They stated that if they were unable to complete the resident's preferred tub bath or shower, they would complete a bed bath, which included washing the resident's hair. They stated that when they charted 'not applicable' that meant that the resident had not received a bed bath, tub bath or a shower; it was missed. They all stated that they often worked short throughout the home and that baths rarely were picked up in the next 24-48 hours as the contingency plan indicated. They recorded any missed baths on the daily report sheet; however, they admitted that the information was not always captured there.

The Inspector reviewed the POC documentation for seven additional residents and noted that between March 9, and April 4, 2016, all seven residents had at least one bed bath charted when the indicated preference in their care plan was a tub bath.

Based on the open shift report, provided by the Manager of Administration, the home was short on the following dates on a specific unit and that bed baths were given; rather than the preferred tub bath on day shift:

- March 12, 2016- short one PSW (6 hour shift)
- March 19, 2016- short one PSW (6 hour shift) and another PSW for half their shift (4 hours)
- March 20, 2016- short one PSW (6 hour shift) and another PSW for six and a half hours
- March 26, 2016- short two PSW's
- March 27, 2016- short one PSW
- March 28, 2016- short one PSW for three hours of their eight hour shift
- April 3, 2016- short one PSW for six and a half hours
- April 4, 2016- short one PSW (6 hour shift)

The Administrator of the home provided the Inspector with a summary of shortages since the compliance date of February 5, 2016. The summary compared the number of budgeted hours for PSWs and the number of hours the home was short staffed. Over the 60 day period, from February 5, to April 4, 2016, day shift was short staffed 48 times, evening shift was short staffed 51 times, and night shift was short staffed 30 times. [s. 31. (3)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols for the Medication Management System were implemented.

On April 7, 2016, on a specific unit, Inspector #612 observed that resident #019's medicated cream was left accessible to residents, on a PSW's cart in the hallway.

The Inspector interviewed PSW #118 who stated that the medicated creams should have been returned to the RPN after they were applied. The PSW took resident #019's medicated cream and brought it to the nurses' station where it was placed in a basket with other residents medicated creams.

This basket was left at the nurses' station, located across from the dining room, accessible to other residents for fifteen minutes until another PSW brought it to the RPN.

On April 8, 2016, on another unit, the Inspector observed two clear plastic bags left accessible to residents on a PSW's cart, located in the hallway. One contained prescription creams for resident #019 and the other contained prescription creams for resident #003.

During an interview, PSW #125 stated to the Inspector that the medicated cream was provided to the PSW by the RPN at the beginning of the shift and it was the expectation of the home that the medicated cream was returned to the RPN after the PSW had applied it. This was confirmed by RPN #116.

The Inspector reviewed the home's policy titled "Medication Administration"; last reviewed May 8, 2014. It stated that the medication cart contained all the medications except refrigerated items and that all areas where drugs were stored shall be locked

at all times, when not in use. For the application of prescription creams, see Resident Care "Medication Administration Prescription Cream Topical Application" policy and procedure.

The Inspector reviewed the home’s policy "Medication Administration Prescription Cream Topical Application"; last reviewed May 8, 2014. The policy stated that the registered nursing staff member provided the prescription cream to the PSW as ordered for the resident and the PSW would return the cream to the registered nursing staff member after completing the procedure.

The Inspector interviewed Program Coordinator (PC) #103 who stated that the medicated cream should have been provided to the PSW by the RPN just prior to application; after the PSW applied the medicated cream, they would to return it to the RPN. This was confirmed by the Manager of Resident Care (MRC). [s. 114. (3) (a)]

Issued on this 24 day of May 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de sions de longue durée

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159 Cedar Street, Suite 403
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SARAH CHARETTE (612) - (A1)

Inspection No. / No de l'inspection : 2016_320612_0010 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 000979-16 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : May 24, 2016;(A1)

Licensee / Titulaire de permis : THE CITY OF GREATER SUDBURY
200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3

LTC Home / Foyer de SLD : PIONEER MANOR
960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Brenda Loubert

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 THE CITY OF GREATER SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_391603_0029, CO #009;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that:

1. Retraining is provided to all staff involved in the development and implementation of resident plans of care to ensure there is clear direction to staff and others who provide direct care.

2. A written record is kept of the retraining which includes who participated in the retraining, when it occurred and what it entailed.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A previous compliance order (CO) #009 was issued on January 8, 2016, to address the licensee's failure to comply with s. 6. (1) (c) of the LTCHA, 2007 during Resident Quality Inspection (RQI) #2015_391603_0029(A1).

The CO required the licensee to prepare, submit, and implement a plan to ensure that there was a plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident. The plan was to include:

i) Education and retraining for all staff involved in developing residents' written plans of care, including the risks associated with the lack of clear directions to staff and others who provided direct care to the residents.

The compliance plan was to be submitted by January 22, 2016, with full compliance by February 5, 2016.

In an interview with the Manager of Resident Care (MRC), they stated that additional online training modules were added for the year 2016, one titled "Resident Care Plans- Updating of"; the other titled "Point of Care Documentation".

The Inspector reviewed the training records which indicated that 42 per cent of staff had not completed the "Resident Care Plans- Updating of" training and 47 per cent of staff had not completed the "Point of Care Documentation" training.

The MRC and the Administrator stated in an interview that an 'interoffice correspondence' was distributed to all staff who had access to e-mail which provided a new process for reviewing residents plans of care based on the orders from RQI #2015_391603_0029(A1). The 'interoffice correspondence' was posted in all units, and was accessible by all staff. The Administrator stated it was the staff's responsibility to read the 'interoffice correspondence'. The Administrator was unable to confirm if 100 per cent of staff had reviewed it. Although all staff were required to read the 'interoffice correspondence', the Administrator stated that it was not a replacement for the training.

The MRC and the Administrator of the home stated that they had allowed staff until December 1, 2016, to complete the training and that there was a disciplinary process in place if staff had not completed the training by then. The MRC confirmed that not all staff had completed the training by the compliance date of February 5, 2016.

Previously, on August 24, 2015, during inspection #2015_391603_0025, a voluntary plan of correction (VPC) was issued and three previous COs have been issued; one on October 2, 2014, from inspection #2014_283544_0021, one on April 24, 2014,

from inspection #2014_140158_0003 and one on November 6, 2013, from inspection #2013_138151_0030.

The decision to re-issue this compliance order was based on the fact that all staff had not completed the retraining as outlined in CO #009 from inspection #2015_391603_0029(A1).

It is a condition that the licensee shall comply with orders made under the LTCHA (s. 101(3) of the LTCHA). The licensee has failed to comply with this condition by failing to comply with CO #009 issued on January 8, 2016. (612)

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

Sep 06, 2016

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2015_391603_0029, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that:

1. Retraining is provided to all staff related to the home's abuse policy, and retraining is provided to direct care staff related to Responsive Behaviours and the requirement to provide care to all residents, as identified in their plan of care.

2. A written record is kept of the retraining which includes who participated in the retraining, when it occurred and what it entailed.

Grounds / Motifs :

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

A previous CO #001 was issued on January 8, 2016, to address the licensee's failure to comply with s. 19(1) of the LTCHA, 2007 during RQI #2015_391603_0029(A1).

The CO required the licensee to prepare, submit, and implement a plan for achieving compliance with the LTCHA, 2007, s. 19(1). The plan was to include:

i) What steps the licensee would take to ensure that all residents in the home were protected from abuse and/or neglect by the staff, including training on the home's abuse policies, training related to the management of responsive behaviours, and training related to the requirements to provide care to all residents, as identified in their plan of care.

The compliance plan was to be submitted by January 22, 2016, with full compliance by February 5, 2016.

Inspector #612 requested training records related to the, "Resident Abuse/Neglect policy". The Inspector noted that the title of the policy had changed to "Promoting Zero Tolerance of Abuse and Neglect of Residents". The MRC stated that the test at the end of the presentation had changed; staff were now required to achieve a grade of 100 per cent to complete the training.

In an interview, the MRC confirmed that 49 per cent of the staff had not completed the training titled "Promoting Zero Tolerance of Abuse/Neglect of Residents".

The Inspector reviewed the additional training records provided by the MRC and noted that 44 per cent of staff had not completed the training related to the "Responsive Behaviours" Program and 62 per cent of registered staff had not completed the "Managing Responsive Behaviours" training.

Additional training records were provided by the MRC related to "Resident Care Plans- Updating of", which 42 per cent of staff had not completed and "Point of Care Documentation", which 47 per cent of the PSW's had not completed.

The MRC and the Administrator stated in an interview that an 'interoffice correspondence' was distributed to all staff who had access to e-mail to update them on the policy changes as well as changes made based on the compliance orders from RQI #2015_391603_0029(A1). The 'interoffice correspondence' was posted in all units, and was accessible by all staff. The Administrator of the home stated it was the staff's responsibility to read the 'interoffice correspondence'. The Administrator was unable to confirm if 100 per cent of staff had reviewed it. Although all staff were required to read the 'interoffice correspondence', the Administrator stated that it was not a replacement for the training.

The MRC and the Administrator of the home stated that they had allowed staff until December 1, 2016, to complete the training and that there was a disciplinary process in place if staff had not completed the training by then. The MRC confirmed that not all staff had completed the training by the compliance date of February 5, 2016.

Previously, a CO was issued on November 6, 2013, during inspection #2013_138151_0030.

The decision to re-issue this compliance order was based on the fact that all staff had not completed the retraining as outlined in CO #001 from inspection #2015_391603_0029(A1).

It is a condition that the licensee shall comply with orders made under the LTCHA (s. 101(3) of the LTCHA). The licensee has failed to comply with this condition by failing to comply with CO #001 issued on January 8, 2016. (612)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

Sep 06, 2016

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant: 2015_391603_0029, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee shall ensure that:

1. All required staff complete retraining on the home s, "Promoting Zero Tolerance of Abuse and Neglect of Residents".

2. A written record is kept of the retraining which includes who participated in the retraining, when it occurred and what it entailed.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A previous CO #002 was issued on January 8, 2016, to address the licensee's failure to comply with s. 20(1) of the LTCHA, 2007 during the RQI #2015_391603_0029(A1).

The CO required the licensee to prepare, submit, and implement a plan for achieving compliance with the LTCHA, 2007, s. 20(1). The plan was to include:

i) Steps the licensee will take to ensure that all staff, including management staff, received retraining on the home's current policy Resident Abuse/Neglect.

The compliance plan was to be submitted by January 22, 2016, with full compliance by February 5, 2016.

Inspector #612 requested training records related to the, "Resident Abuse/Neglect policy". The Inspector noted that the title of the policy had changed to, "Promoting Zero Tolerance of Abuse and Neglect of Residents". The MRC stated that the test at the end of the presentation had changed and staff were now required to achieve a grade of 100 per cent to complete the training.

In an interview, the MRC confirmed that 49 per cent of staff had not completed the training titled, "Promoting Zero Tolerance of Abuse/Neglect of Residents".

The MRC and the Administrator stated in an interview that an 'interoffice correspondence' was distributed to all staff who had access to e-mail to update them on the policy changes; as well as, changes made based on the compliance orders from RQI #2015_391603_0029(A1). The 'interoffice correspondence' was posted in all units, and was accessible by all staff. The Administrator of the home stated it was the staff's responsibility to read the 'interoffice correspondence'. The Administrator was unable to confirm if 100 per cent of staff had reviewed it. Although all staff were required to read the 'interoffice correspondence', the Administrator stated that it was not a replacement for the training.

The MRC and the Administrator of the home stated that they had allowed staff until December 1, 2016, to complete the training and that there was a disciplinary process in place if staff had not completed the training by then. The MRC confirmed that not all staff had completed the training by the compliance date of February 5, 2016.

Previously, a written notification (WN) was issued during inspection #2015_282543_0018.

The decision to re-issue this compliance order was based on the fact that not all staff completed the required retraining as requested in CO #002, from inspection #2015_391603_0029(A1).

It is a condition that the licensee shall comply with orders made under the LTCHA (s. 101(3) of the LTCHA). The licensee has failed to comply with this condition by failing to comply with CO #002 issued on January 8, 2016. (612)

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

Sep 06, 2016(A1)

Order # /
Ordre no : 004

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

Linked to Existing Order /
Lien vers ordre existant: 2015_391603_0029, CO #006;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall ensure that:

1. Retraining is provided to all direct care staff related to the home's, "Responsive Behaviours Program" and "Managing Responsive Behaviours".

2. A written record is kept of the retraining which includes who participated in the retraining, when it occurred and what it entailed.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A previous CO #006 was issued January 8, 2016, to address the licensee's failure to comply with s. 54 of O. Reg. 79/10 during the RQI #2015_391603_0029(A1).

The CO required the licensee to ensure that:

i) Training was provided to all direct care staff related to the "Responsive Behaviours Prevention, Assessment and Management of" and Resident Care, "Documentation Shift to Shift Report" policies.

The Inspector reviewed the training records provided by the MRC and noted that 44 per cent of staff had not completed the training related to the "Responsive Behaviours" program and 62 per cent of registered staff had not completed the "Managing Responsive Behaviours" training.

The MRC and the Administrator stated in an interview that an 'interoffice correspondence' was distributed to all staff who had access to e-mail to update them on the policy changes; as well as, changes made based on the compliance orders from RQI #2015_391603_0029(A1). The 'interoffice correspondence' was posted in all units, and was accessible by all staff. The Administrator of the home stated it was the staff's responsibility to read the 'interoffice correspondence'. The Administrator was unable to confirm if 100 per cent of staff had reviewed it. Although all staff were required to read the 'interoffice correspondence', the Administrator stated that it was not a replacement for the training.

The MRC and the Administrator of the home stated that they had allowed staff until December 1, 2016, to complete the training and that there was a disciplinary process in place if staff had not completed the training by then. The MRC confirmed that not all staff had completed the training by the compliance date of February 5, 2016.

The decision to re-issue this compliance order was based on the fact that retraining was not completed as ordered in CO #006 from inspection #2015_391603_0029(A1).

It is a condition that the licensee shall comply with orders made under the LTCHA (s. 101(3) of the LTCHA). The licensee has failed to comply with this condition by failing to comply with CO #006 issued on January 8, 2016. (612)

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

Sep 06, 2016

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 : 005

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

Linked to Existing Order / Lien vers ordre existant: 2015_391603_0029, CO #004;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that:

1. Retraining is provided to all direct care staff related to the home's, "Skin and Wound Care", "Responsive Behaviours" and "Medication Administration" policies.

2. A written record is kept of the retraining which includes who participated in the retraining, when it occurred and what it entailed.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A previous CO #004 was issued on January 8, 2016, to address the licensee's failure to comply with s. 8. (1) (b) of O.Reg. 79/10 during the RQI #2015_391603_0029(A1).

The CO required the licensee to ensure that all staff and others who provided direct care to residents received training on the following policies:

i) "Skin Care (cross reference Skin Integrity- Preventive Assessment and Treatment)", last revised May 1, 2014, specifically that assigned PSWs were to complete a full resident head to toe assessment once per week and report all concerns to registered staff immediately and registered staff were to complete weekly wound assessment for all resident who had skin breakdown, according to policy.

ii) "Responsive Behaviours Prevention, Assessment and Management of", last revised December 5, 2014, specifically ensuring that if a resident demonstrated escalating, potentially injurious behaviours, DOC charting was initiated immediately and the resident was referred to BSO.

iii) "Medication Administration", last revised May 8, 2014, specifically ensuring the dignity and privacy of the resident was maintained and that eye/ear drops, inhalers, patches, g-tube or any type of injections were not to be administered in a public area, ie. dining room, nursing lounge, etc.

The compliance date of the order was February 5, 2016.

The Inspector reviewed the training records provided by the Manager of Resident Care (MRC):
- Skin and Wound care was completed over two modules, 60 per cent of staff had not completed module one and 61 per cent had not completed module two.
- The responsive behaviours training had not been completed by 44 per cent of staff.
- Medication administration had not been completed by 56 per cent of staff.

The MRC and the Administrator stated in an interview that an 'interoffice correspondence' was distributed to all staff who had access to e-mail to update them on the policy changes as well as changes made based on the compliance orders from RQI #2015_391603_0029(A1). The 'interoffice correspondence' was posted in all units, and was accessible by all staff. The Administrator of the home stated it was the staff's responsibility to read the 'interoffice correspondence'. The Administrator was unable to confirm if 100 per cent of staff had reviewed it. Although all staff were required to read the 'interoffice correspondence', the Administrator stated that it was not a replacement for the training.

The MRC and the Administrator of the home stated that they had allowed staff until December 1, 2016, to complete the training and that there was a disciplinary process

in place if staff had not completed the training by then. The MRC confirmed that not all staff had completed the training by the compliance date of February 5, 2016.

The decision to re-issue this compliance order was based on the fact that all staff had not completed the retraining as outlined in CO #004 from inspection #2015_391603_0029(A1).

It is a condition that the licensee shall comply with orders made under the LTCHA (s. 101(3) of the LTCHA). The licensee has failed to comply with this condition by failing to comply with CO #004 issued on January 8, 2016. (612)

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

Sep 06, 2016

Order # /
Ordre no : 006

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

Linked to Existing Order /
Lien vers ordre existant: 2015_391603_0029, CO #005;

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 shall ensure that:

1. Their staffing mix is evaluated and updated to ensure that the residents' care and safety needs are met.

2. All resident's receive their preferred and scheduled bath as identified in their care plan.

3. A record is kept of the evaluation including who participated in the review, the date of the review, the changes made and the date the changes are implemented.

Grounds / Motifs :

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

A previous CO #005 was issued January 8, 2016, to address the licensee's failure to comply with s. 31 (3) of O.Reg. 79/10 during RQI Inspection #2015_391603_0029(A1).

The CO required the licensee to prepare, submit, and implement a plan to ensure that the staffing mix was consistent with residents' assessed care and safety needs, and that it met the requirements set out in the Act and this Regulation to achieve compliance with O. Reg. 79/10, s. 31(3). The plan was to include:

i) Steps the licensee would take to ensure that all residents received their preferred and scheduled baths that had been identified in their care plan.

The plan was due January 22, 2016, with full compliance expected by February 5, 2016.

During the course of the Follow-Up Inspection, Inspector #612 also inspected four complaints received by the Director related to staffing concerns within the home and that residents had not received their preferred bath as indicated in their care plan.

During an interview with the MRC and the Administrator, they stated that the staffing plan in the home had been reviewed and a plan was in place to ensure that residents received their preferred and scheduled baths. They stated that additional staff would be scheduled within 24-48 hours of a short shift and a PSW would be assigned to complete the missed baths.

The Inspector interviewed resident #023, #024 and #025. They all confirmed that in the few weeks prior to the current inspection, they had received bed baths or had not received a tub bath, as a result of the home being short.

The Inspector reviewed resident #023's documented care in Point of Care (POC). The resident had received a bed bath on two specific dates. A review of the resident's plan of care indicated that the resident's preference was a tub bath.

The Inspector reviewed resident #024's documented care in POC. The resident had received a bed bath on three specific dates. A review of the resident's plan of care indicated that the resident's preference was a tub bath.

The Inspector reviewed resident #025 documented care in POC. The resident received a bed bath on a specific date, and on another day, their bath was charted as 'not applicable'. The resident's plan of care indicated that the resident's preference was a tub bath.

The Inspector interviewed PSW #114, #115, and #118. They stated that if they were unable to complete the resident's preferred tub bath or shower, they would complete a bed bath, which included washing the resident's hair. They stated that when they charted 'not applicable' that meant that the resident had not received a bed bath, tub bath or a shower; it was missed. They all stated that they often worked short throughout the home and that baths rarely were picked up in the next 24-48 hours as the contingency plan indicated. They recorded any missed baths on the daily report sheet; however, they admitted that the information was not always captured there.

The Inspector reviewed the POC documentation for seven additional residents and noted that between March 9, and April 4, 2016, all seven residents had at least one bed bath charted when the indicated preference in their care plan was a tub bath.

Based on the open shift report, provided by the Manager of Administration, the home was short on the following dates on a specific unit and that bed baths were given; rather than the preferred tub bath on day shift:

- March 12, 2016- short one PSW (6 hour shift)
- March 19, 2016- short one PSW (6 hour shift) and another PSW for half their shift (4 hours)
- March 20, 2016- short one PSW (6 hour shift) and another PSW for six and a half hours
- March 26, 2016- short two PSW's
- March 27, 2016- short one PSW
- March 28, 2016- short one PSW for three hours of their eight hour shift
- April 3, 2016- short one PSW for six and a half hours
- April 4, 2016- short one PSW (6 hour shift)

The Administrator of the home provided the Inspector with a summary of shortages since the compliance date of February 5, 2016. The summary compared the number of budgeted hours for PSWs and the number of hours the home was short staffed. Over the 60 day period, from February 5, to April 4, 2016, day shift was short staffed 48 times, evening shift was short staffed 51 times, and night shift was short staffed 30 times.

The decision to re-issue this compliance order was based on the fact that resident's did not receive their preferred bath, as indicated in their care plan despite CO #005 which was issued in inspection #2015_391603_0029(A1).

It is a condition that the licensee shall comply with orders made under the LTCHA (s. 101(3) of the LTCHA). The licensee has failed to comply with this condition by failing to comply with CO #005 issued on January 8, 2016. (612)

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

Jun 14, 2016

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 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 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

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions 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

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions 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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24 day of May 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SARAH CHARETTE - (A1)

Service Area Office /
Bureau régional de services : Sudbury