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 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 8, 2018	2017_630589_0019	027121-17	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

Rockcliffe Care Community
3015 LAWRENCE AVENUE EAST SCARBOROUGH ON M1P 2V7

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

JOANNE ZAHUR (589), BABITHA SHANMUGANANDAPALA (673)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): December 5, 6, 7, 8, 11, 12, 13, and 14, 2017.

Follow-up log #010388-16 related to compliance order (CO) #001 served in report # 2016_302600_0006 (A1) related to O. Reg. 79/10, s. 73 (1) was inspected concurrently during this resident quality inspection (RQI).

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aides (HA), Unit Scheduling Clerk (USC), Medical Pharmacies consulting pharmacist, Director of Environmental Services (DES), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) coordinator, Occupational Therapist (OT), Physiotherapist (PT), Director of Dietary Services (DDS), Resident Coordinator (RC), Residents, Substitute Decision Maker (SDM), President's of Residents' Council and Family Council.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of the medication administration system, staff and resident interactions and the
provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

4 WN(s)
1 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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 provide for a staffing mix that is consistent with the residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

During the RQI, the inspector was approached by staff #129 who complained that on most days the home is working short staffed of PSWs and that he/she is concerned about resident care being compromised. On the same day, the inspector was approached by resident #022 who also complained about PSW staffing shortages in the home and that he/she is concerned that residents are being neglected as a result of these staff shortages. Resident #022 further stated that he/she can speak for him/herself but is concerned for the residents that cannot speak up for themselves. The inspector also received staffing shortage concerns from resident #023 during the RQI. Resident #023 voiced concerns about the staffing shortages, that sick calls and vacations are not being replaced and residents are not getting proper care. When the inspector asked if he/she has missed any baths/showers, resident #023 stated, "no" that he/she has

sponge baths and that is acceptable to him/her. Resident #023 further stated that he/she receives meals in his/her room and has to wait until both meal sittings are complete.

Review of resident #025's health record revealed he/she is bathed on two identified days per week requiring one staff limited assistance and that he/she prefers showers. A review of the PSW flow sheets completed on the point of care (POC) revealed that on an identified date in December 2017, resident #025 did not receive his/her scheduled shower. Resident #025's cognitive status indicated a cognitive impairment and therefore was unable to respond appropriately during an interview.

Review of resident #027's health record revealed that he/she is showered on two identified days per week and as necessary, requiring two staff total assistance. A review of the PSW flow sheets completed on the POC revealed that on an identified date in December 2017, resident #027 did not receive his/her scheduled shower. Resident #027's cognitive status indicated a cognitive impairment and therefore was unable to respond appropriately during an interview.

In interviews, staff #118 and #108 stated they had worked on an identified date in December, 2017, and that an identified resident home area (RHA) where residents' #025 and #027 reside was short staffed by three PSWs. Staff #108 and #118 further stated they tried their best to provide scheduled showers however some residents only received bed baths on that day.

Review of the daily staffing roster for the above mentioned identified date in December, 2017, revealed that the home was short staffed by six PSWs on day shift, three on the second floor and three on the third floor.

During the RQI, resident #029 requested to speak to the inspector regarding staff shortages on his/her RHA and that he/she does not receive showers as per bathing schedule. On an identified date in December 2017, resident #029 stated that he/she had to make a special request to receive his/her shower because they were short staffed. Resident #029 further stated there were other dates where he/she had missed showers but was unable to recall actual dates. States that on one occasion, a RN gave him/her his/her shower because they were short staffed. Review of the daily staffing roster for this identified date in December 2017 revealed the RHA was short staffed by four PSWs.

In interviews, staff #121, #118, #119 and #120 stated when the RHA's are short staffed and scheduled showers are not able to be provided, a bed bath is provided to the

residents.

In an interview, staff #105 stated that he/she had started the USC position at the home in November 2017. Staff #105 further stated that there were PSWs on approved vacation in November and December and that not all of these absences had not been filled as well there were daily sick calls that were required to be filled. Staff #105 was unaware that staff could be pre-booked for approved vacations and that moving forward would ensure that any approved vacation would be filled prior to finalizing the staffing schedule.

Review of the daily staffing roster indicated the following staffing;
Ground and First floors:
Day shift: four PSWs, Evening shift: three PSWs, Night shift: one PSW on Ground floor and two PSWs on First floor, and
Second and Third floors:
Day shift: eight PSWs, Evening shift: six PSWs, Night shift: three PSWs, on each floor respectively.

A review of the PSW staffing schedule for a six week period from November 2, 2017, to December 14, 2017, indicated a shortage of PSW hours as follows:
November 2 to November 8, 2017; 82.5 hours,
November 9 to November 15, 2017; 142.5 hours,
November 16 to November 22, 2017; 135 hours,
November 23 to November 29, 2017; 285 hours,
November 30 to December 6, 2017; 195 hours, and
December 7 to December 14, 2017; 397.5 hours.

Interviews with registered staff and PSWs during the inspection revealed that the home is short staffed on a daily basis and that staff are getting burned out and stressed from constantly working short staffed and not being able to provide all assessed care to the residents.

The daily staffing roster also indicated that PSWs identified to be on modified duties were not consistently replaced. Staff #104 stated that PSWs on modified duties are replaced based on any physical limitations that hinders their ability to provide resident care. PSWs on modified duties are required to provide a functional abilities form (FAF) that has been completed by their physicians that identifies their physical abilities. Currently there are only two staff, #110 and #138, that have restricted physical abilities and are to be replaced when scheduled to work.

In an interview, staff #104 stated that since the home is holding staff accountable for resident care needs not provided, they are seeing push back from the staff. Staff #104 further stated they have current vacancies to post and have conducted PSW interviews to fill these positions and build on their casual pool however the caliber of applicants has not met their requirements. Staff #104 stated that hiring PSWs has been a challenge as out of 30 applicants interviewed, only two PSWs were hired. Staff #104 also stated that in recent weeks two applicants from an agency had been interviewed and that they did not have the proper PSW credentials required. Staff #104 further stated that a staffing agency has only been used to provide one to one staffing, however since the increase in staff shortages in recent weeks the agency has been utilized to assist with staff shortages within the home. Staff #104 also stated that corporate office is working on developing a casual pool of registered staff and PSWs that all homes can access for staffing. Staff #104 acknowledged that PSW staffing shortages within the home has resulted in residents not receiving the care they need.

The severity is minimum harm/risk or potential for actual harm/risk related to voiced concerns from staff and residents that resident care specifically, showers were not being provided due to staff shortages. The scope is related to three residents and the previous compliance history reveals previous non-compliances not related to O. Reg. r. 31. A review of the staffing roster for a six week period revealed daily staff shortages therefore due to the ongoing staff shortages and the potential for actual harm/risk to residents a compliance order is warranted. [s. 31. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

A follow up inspection was conducted for compliance order #001 served on RQI report #2016_302600_0006 (A1) related to O. Reg. 79/10, s. 73 (1), related to the licensee's failure to ensure that proper techniques, including safe positioning, were used to assist resident #001 and #034 with eating.

As both residents' #001 and #034 were no longer in the home, three other residents, resident #014, #015, and #016, were randomly selected by the inspector to complete this follow up inspection.

Review of resident #016's health record revealed that resident #016 had physical limitations requiring total dependence with nutritional requirements. Further review of resident #016's current plan of care revealed self care performance deficit related to underlying health conditions. The goal for resident #016 included maintaining his/her current level of function with his/her ADL's. Another focus of the plan of care was a nutritional problem or potential nutritional problem related to underlying health conditions affecting oral intake therefore requiring resident #016 be positioned upright during meal times.

Review of resident #016's progress notes revealed a physiotherapy note which stated that resident #016 was observed to not be positioned upright while up in a mobility device. The physiotherapist noted, and informed the nursing staff that using a positioning aid while resident #016 was up in the mobility device would provide external support.

Observations conducted by the inspector during meal service on an identified date in December, revealed resident #016's was not positioned upright and was spitting food back up and making coughing sounds as staff #131 encouraged him/her to swallow. No positioning aid was in place to aid resident #016.

Observations conducted by the inspector during meal service on an alternate date in December 2017, revealed staff #132 was feeding resident #016 who again, was not positioned upright as required. When the inspector asked staff #132 if resident #016 was positioned upright, he/she adjusted resident #016's mobility device to an upright position

and then attempted unsuccessfully to straighten resident #016's body. When asked if there is anything else that can be used to position resident #016, staff #132 responded that a positioning aid could be used. Staff #135 was noted to be supervising the dining room at this time.

The inspector brought the concern to the attention of staff #133 who stated that resident #016 was not in an upright position and this could present a risk. Staff #133 proceeded to assist staff #132 to obtain a positioning aid and to reposition resident #016 with staff #134 assistance.

In an interview, staff #132 stated that he/she was not aware of resident #016's plan of care as resident #016 is not part of his/her assignment, and that he/she was assisting resident #016 due to a staffing shortage that day. Staff #132 further stated that he/she received training on the proper positioning of residents for feeding, but it was just to read over some information in a package, and that there was no demonstration for him/her to understand. Staff #132 acknowledged that resident #016 had not been safely positioned as his/her mobility device had been slightly tilted, and his/her body had not been in an upright position.

In an interview, staff #135 stated that his/her responsibilities relating to the supervision of the dining room included ensuring that residents were sitting upright. Staff #135 defined sitting upright as the chairs being at a 90 degree angle, and stated that the home's training was not clear in relation to positioning of resident's bodies.

In an interview, staff #134 stated that resident #016's plan of care stated to keep him/her at an upright position due to a risk of altered ingestion of food and that the plan of care had not been followed. Staff #134 further stated that a positioning aid should have been used to position resident #016 properly.

In an interview, staff #127 stated that all staff had been provided training on positioning of residents during feeding after the initial order was received on November 2016. Review of the home's training records confirmed that the above identified staff had received this training.

In interviews, staff #104 and staff #127 confirmed that resident #016's plan of care related to positioning during feeding was not followed by staff #131 and staff #132, presenting a safety risk.

The scope is isolated to resident #016, the severity is actual harm/risk as resident #016 was observed coughing while being fed. The previous compliance history includes a compliance order served in RQI report #2016_302600_0006 (A1) related to O. Reg. 79/10, s. 73 (1) on November 7, 2016, related to the licensee's failure to ensure that proper techniques, including safe positioning, were used to assist residents with eating. Due to ongoing non compliance with this legislation, a compliance order will be re-issued under O. Reg. r. 73 (1). [s. 73. (1) 10.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of resident care equipment including personal assistance services devices.

Unclean ambulation equipment triggered during stage one of the resident quality

inspection for resident #002 as his/her mobility device was observed to have food particles.

Review of the home's policy titled Equipment, Maintenance & Cleaning – Nursing & Resident Care, policy number, VII-H-10.30, dated March 2017, stated that the procedure in the home was that with each use, staff were to observe the cleanliness and safety of equipment and clean as required according to the Nursing & Resident Care Equipment Cleaning Frequency Schedule. Review of the Nursing & Resident Care Equipment Cleaning Frequency Schedule revealed that wheelchairs were not on this list.
The policy further stated that the home was to complete cleaning and inspection audits as assigned and forward to the DOC. The responsibilities of the DOC was to include equipment inspection and cleaning in specific job routines, provide team members with an appropriate checklist to complete the task, and to review all routine cleaning and inspection checklists monthly.

Observations of resident's wheelchairs revealed the following over a period of three days during the RQI:
-Resident #002 had white food particles on his/her mobility device seat on two identified days,
-Resident #010's mobility device was dusty with white particles all over it on all three days, and
-Resident #011's mobility device had white particles, and a brown food substance stuck on the wheelchair on all three days.

Record review of POC documentation between a seven day period in December 2017 revealed the following:
-Resident #002's mobility device had been cleaned by staff #123 on an identified date in December 2017, at 0122 hours,
-Resident #010's mobility device had been cleaned by staff #122 on an identified date in December 2017, at 0648 hours, and
-Resident #011's mobility device had been cleaned by staff #123 on an identified date in December 2017 at 0103 hours.
Staff #103 observed the above mentioned mobility devices and confirmed that they did not appear to have been cleaned on nights as per the schedule; therefore, the staff were not following the home's process.

In an interview, staff #122 stated that he/she only washed the seat of resident #010's mobility device as she did not have time to clean the whole wheelchair.

In an interview, staff #123 stated that the home's process for cleaning mobility devices is to clean them in the shower room, or clean them using a towel with soap and water and send the mobility devices covers to the laundry if they are dirty.

In an interview, staff #120 stated that mobility devices are cleaned using wet wipes, and if they are really dirty, the shower hose in the shower room is used to clean them. Observation of the wet wipes revealed that it was not a disinfectant.

In an interview, staff #112 stated that wet towels are used to clean the mobility devices, or they are taken to the shower room to be cleaned; however, he/she was not aware of any disinfectant products to be used.

In an interview, staff #103 stated that mobility equipment cleaning clinics perform deep cleaning of mobility devices twice a year and that the home's process for cleaning resident's mobility devices was to be completed on nights twice a week, as per the schedules in POC and in between as needed using microfiber, cloth wipes or towels. Staff #103 further stated the mobility devices are to be washed in the shower room, and if the cushions are dirty, the covers can be removed and sent to laundry for washing. Staff #103 stated that mobility devices are disinfected by housekeeping staff when needed, and that this is scheduled as per staff #124.

In an interview, staff #124 stated that night staff are designated to clean the mobility devices using towels and a diluted disinfectant, which are stored in utility rooms located on each floor. He/she confirmed that if the staff are not aware of, or are not using the disinfectant, they are not following the home's process.

In an interview, staff #104 stated that the home does not currently do cleaning and inspection audits nor do they currently review all routine cleaning and inspection checklists monthly as outlined in the home's policy. Staff #104 further stated that the home's policy does not describe the procedure for disinfecting mobility devices, and that there had not been any recent staff education on this procedure. Staff #104 confirmed that staff #122 and staff #123 had not followed the home's expectations on how mobility devices are to be cleaned and disinfected. [s. 87. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of resident care equipment including personal assistance services devices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident's SDM and to the residents attending physician.

During the RQI, a review of medication incidents and adverse drug reactions during the past quarter was conducted as part of the mandatory medication inspection protocol.

A review of the home's medication incidents revealed two medication incidents had occurred involving resident #030 and resident #031.

A review of the medication incident reports revealed that resident #030's SDM nor the attending physician had been notified. As well, a review of resident #031's medication incident report also revealed that the attending physician had not been notified.

In interviews, staff #106 and staff #113 revealed that resident #030's and resident #031's attending physician had not been notified of the above mentioned medication incidents nor had resident #030's SDM been notified.

Staff #104 acknowledged that registered staff had failed to notify the attending physicians for residents #030 and #301 of the medication incidents nor had resident #030's SDM been notified. [s. 135. (1)]

Issued on this 16th day of January, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE ZAHUR (589), BABITHA SHANMUGANANDAPALA (673)
Inspection No. / No de l'inspection :	2017_630589_0019
Log No. / No de registre :	027121-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 8, 2018
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Rockcliffe Care Community 3015 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1P-2V7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shelley Fazackerley

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:

Order # / Ordre no : 001

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

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 prepare, submit and implement a plan to ensure that the staffing plan 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.
The plan will include, at a minimum, the following elements:
1. A hiring plan that ensures the home has all vacant staff positions filled and a sufficient casual/part-time staffing pool in place in six months,
2. An alternate staffing plan that ensures the home is staffed appropriately while implementing their hiring plan and that the alternate staffing plan includes education in the home's practices related to resident care,
3. A documented monitoring system to ensure that all residents within the home receive at a minimum two baths/showers twice a week by method of his/her choice when short staffed and that also includes alternate baths/shower days when not provided as per their plan of care, and
4. Provide sufficient training to the unit scheduling clerk that includes job expectations and requirements related to staffing.

Please submit the plan to joanne.zahur@ontario.ca no later than January 19, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan provide for a staffing mix that is consistent with the residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

During the RQI, the inspector was approached by staff #129 who complained that on most days the home is working short staffed of PSWs and that he/she is concerned about resident care being compromised. On the same day, the inspector was approached by resident #022 who also complained about PSW staffing shortages in the home and that he/she is concerned that residents are being neglected as a result of these staff shortages. Resident #022 further stated that he/she can speak for him/herself but is concerned for the residents that cannot speak up for themselves. The inspector also received staffing shortage concerns from resident #023 during the RQI. Resident #023 voiced concerns about the staffing shortages, that sick calls and vacations are not being replaced and residents are not getting proper care. When the inspector asked if he/she has missed any baths/showers, resident #023 stated, "no" that he/she has sponge baths and that is acceptable to him/her. Resident #023 further stated that he/she receives meals in his/her room and has to wait until

both meal sittings are complete.

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Review of the daily staffing roster for the above mentioned identified date in December, 2017, revealed that the home was short staffed by six PSWs on day shift, three on the second floor and three on the third floor.

During the RQI, resident #029 requested to speak to the inspector regarding staff shortages on his/her RHA and that he/she does not receive showers as per bathing schedule. On an identified date in December 2017, resident #029 stated that he/she had to make a special request to receive his/her shower because they were short staffed. Resident #029 further stated there were other dates where he/she had missed showers but was unable to recall actual dates. States that on one occasion, a RN gave him/her his/her shower because they were short staffed. Review of the daily staffing roster for this identified date in December 2017 revealed the RHA was short staffed by four PSWs.

In interviews, staff #121, #118, #119 and #120 stated when the RHA's are short

staffed and scheduled showers are not able to be provided, a bed bath is provided to the residents.

In an interview, staff #105 stated that he/she had started the USC position at the home in November 2017. Staff #105 further stated that there were PSWs on approved vacation in November and December and that not all of these absences had not been filled as well there were daily sick calls that were required to be filled. Staff #105 was unaware that staff could be pre-booked for approved vacations and that moving forward would ensure that any approved vacation would be filled prior to finalizing the staffing schedule.

Review of the daily staffing roster indicated the following staffing;
Ground and First floors:
Day shift: four PSWs, Evening shift: three PSWs, Night shift: one PSW on Ground floor and two PSWs on First floor, and
Second and Third floors:
Day shift: eight PSWs, Evening shift: six PSWs, Night shift: three PSWs, on each floor respectively.

A review of the PSW staffing schedule for a six week period from November 2, 2017, to December 14, 2017, indicated a shortage of PSW hours as follows:
November 2 to November 8, 2017; 82.5 hours,
November 9 to November 15, 2017; 142.5 hours,
November 16 to November 22, 2017; 135 hours,
November 23 to November 29, 2017; 285 hours,
November 30 to December 6, 2017; 195 hours, and
December 7 to December 14, 2017; 397.5 hours.

Interviews with registered staff and PSWs during the inspection revealed that the home is short staffed on a daily basis and that staff are getting burned out and stressed from constantly working short staffed and not being able to provide all assessed care to the residents.

The daily staffing roster also indicated that PSWs identified to be on modified duties were not consistently replaced. Staff #104 stated that PSWs on modified duties are replaced based on any physical limitations that hinders their ability to provide resident care. PSWs on modified duties are required to provide a functional abilities form (FAF) that has been completed by their physicians that identifies their physical abilities. Currently there are only two staff, #110 and

#138, that have restricted physical abilities and are to be replaced when scheduled to work.

In an interview, staff #104 stated that since the home is holding staff accountable for resident care needs not provided, they are seeing push back from the staff. Staff #104 further stated they have current vacancies to post and have conducted PSW interviews to fill these positions and build on their casual pool however the caliber of applicants has not met their requirements. Staff #104 stated that hiring PSWs has been a challenge as out of 30 applicants interviewed, only two PSWs were hired. Staff #104 also stated that in recent weeks two applicants from an agency had been interviewed and that they did not have the proper PSW credentials required. Staff #104 further stated that a staffing agency has only been used to provide one to one staffing, however since the increase in staff shortages in recent weeks the agency has been utilized to assist with staff shortages within the home. Staff #104 also stated that corporate office is working on developing a casual pool of registered staff and PSWs that all homes can access for staffing. Staff #104 acknowledged that PSW staffing shortages within the home has resulted in residents not receiving the care they need.
(589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 23, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_302600_0006, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the proper techniques to assist residents with eating, including safe positioning of residents who require assistance and that meets the requirements set out in the Act and this Regulation.
The plan will include, at a minimum, the following elements:
1. The development of a sustainable system for ongoing monitoring of the safe positioning of residents during meal and snack services and identify who will be responsible for this monitoring,
2. Develop and provide re-training to all staff who participate in the home's feeding program to be able to identify and implement safe positioning of residents and to recognize the signs of dysphagia while eating and how to apply appropriate interventions when necessary, and
3. Develop an education plan related to proper feeding techniques that is provided annually and as needed for all staff that participate in the home's feeding program.

The plan should be submitted to joanne.zahur@ontario.ca no later that January 19, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

A follow up inspection was conducted for compliance order #001 served on RQI report #2016_302600_0006 (A1) related to O. Reg. 79/10, s. 73 (1) on November 7, 2016, related to the licensee's failure to ensure that proper techniques, including safe positioning, were used to assist resident #001 and #034 with eating.

As both residents' #001 and #034 were no longer in the home, three other residents, resident #014, #015, and #016, who had been assessed to be at high risk for choking, were randomly selected by the inspector to complete this follow up inspection.

Review of resident #016's RAI-MDS quarterly assessment dated November 1, 2017, revealed that resident #016 had physical functioning and structural problems related to eating, and was totally dependent requiring one person physical assist. Resident #016 was also assessed to have functional limitation in

his/her neck and arm with range of motion limitation on one side and partial loss of voluntary movement, and functional limitation in his/her hand with range of motion limitation on one side and full loss of voluntary movement. His/her disease diagnoses included aphasia.

Review of resident #016's current plan of care revealed a focus for activities of daily living (ADL) self care performance deficit related to his/her diagnoses of arthritis, cardiovascular accident, and contracture of arms. The goal for resident #016 included maintaining his/her current level of function in eating and the interventions included the requirement of one staff providing total assistance. Another focus of the plan of care was a nutritional problem or potential nutritional problem related to dysphasia and aphasia, low food intake, and a low Body Mass Index. Interventions for this focus included that the resident be properly positioned when eating and drinking with his/her body seated at a 90 degree angle to the seat in order to reduce risk of choking.

Review of resident #016's progress notes revealed a physiotherapy note dated July 7, 2017 which stated that resident #016 was observed to be leaning to the right side with the head rest turned away and right arm tucked against the waist, he/she was not moving the head or right arm by him/herself. Spinal scoliosis and kyphosis were noted to be exaggerated. The physiotherapist noted, and informed the nursing staff that the arm rest will not serve any purpose as his/her shoulder abduction and elbow extension were limited and that placing a pillow at the waist on the right side will give him/her external support.

On August 2, 2017, a physiotherapy assessment note revealed that resident #016 has increased tone in his/her extremities, progressing towards contractures, and that movement in the right upper extremities had declined. The physiotherapist provided supporting pillows for better positioning in his/her wheelchair.

On December 13, 2017, observations conducted by the inspector during lunch service, revealed resident #016's head and body were leaning to the right side; therefore, his/her body was not at a 90 degree angle. Resident #016 was also observed to be spitting food back up and making coughing sounds as PSW #131 encouraged him/her to swallow. No pillow was in place to aid in positioning resident #016.

On December 14, 2017, during lunch service, PSW #132 was observed feeding

resident #016 who again, was not at a 90 degree angle as he/she was slumped to the right side. When the inspector asked PSW #132 if resident #016 was at a 90 degree angle, he/she adjusted resident #016's wheelchair, which had been slightly tilted, to a 90 degree angle and then attempted unsuccessfully to straighten resident #016's body. When asked if there is anything else that can be used to position resident #016, PSW #132 responded that a pillow could be used. RPN #135 was noted to be supervising the dining room at this time.

The inspector brought the concern to the attention of RC #133 who stated that resident #016 was not at a 90 degree angle and this could present a risk for choking. RC #133 proceeded to assist PSW #132 to obtain a pillow and to reposition resident #016 with RPN #134.

In an interview, PSW #132 stated that he/she was not aware of resident #016's plan of care as resident #016 is not part of his/her assignment, and that he/she was assisting resident #016 due to a staffing shortage that day. PSW #132 further stated that he/she received training on the proper positioning of residents for feeding, but it was just to read over some information in a package, and that there was no demonstration for him/her to understand. PSW #132 acknowledged that resident #016 had not been safely positioned as his/her wheelchair had been slightly tilted, and his/her body had not been at a 90 degree angle.

In an interview, RPN #135 stated that his/her responsibilities relating to the supervision of the dining room included ensuring that residents were sitting upright. RPN #135 defined sitting upright as the chairs being at a 90 degree angle, and stated that the home's training was not clear in relation to positioning of resident's bodies.

In an interview, RPN #134 stated that resident #016's plan of care stated to keep him/her at a 90 degree angle due to risk of choking and that the plan of care had not been followed as he/she was bent to one side as PSW #132 was feeding him/her. RPN #134 further stated that a pillow should have been used to reposition resident #016.

In an interview, DDS #127 stated that all staff had been provided training on positioning of residents during feeding after the initial order received on November 7, 2016. Review of the home's training records confirmed that the above identified staff had received this training.

In interviews, DOC #104 and DDS #127 confirmed that resident #016's plan of care related to positioning during feeding was not followed by PSW #131 and PSW #132 and, presented a safety risk of choking for resident #016.
(673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 23, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 8th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Joanne Zahur

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