Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 8, 2018	2018_730593_0013	028438-17, 009576-18, 011100-18, 011132-18, 013378-18, 025324-18	Complaint

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 Overlea Blvd TORONTO ON M4H 1P4

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

The Salvation Army Ottawa Grace Manor
1156 Wellington Street OTTAWA ON K1Y 2Z3

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

GILLIAN CHAMBERLIN (593), ANANDRAJ NATARAJAN (573)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 11 - 14, 17, 21, 24 - 26, 2018.

Inspector #126 completed a concurrent Critical Incident (CIS) inspection (#2018_683126_0019) during this complaint inspection. The following non-compliance was identified by Inspector #126 and is captured in this report.
s. 6 (1) (c)- related to CIS logs #013018-17, 007357-18, 025375-17

s. 6 (7)- related to CIS log #013018-17
s. 24- related to CIS log #025375-17
s. 8. (1) (b)- related to CIS log #010419-18

The following intakes were completed during this inspection:

Six complaint intakes: Log #013378-18 and log #028438-17 related to resident care concerns, log #009576-18, log #011100-18 and log #011132-18 related to a bed refusal and log #025324-18 related to staffing concerns.

Four critical incident (CIS) intakes: Log #013018-17 related to alleged resident abuse, log #007357-18, log #025375-17 and log #010419-18 related to resident to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Director of Employee Relations, Director of Environmental Services, the Scheduler, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family members and residents.

During the course of the inspection, the Inspector(s) reviewed Critical Incident (CIS) reports, resident health care records, staffing plans and schedules, staff training records, licensee's relevant policies and procedures. In addition the Inspector(s) observed the provision of care and services to residents, the residents environment and observed staff to resident interactions.

In addition to the below listed Inspection Protocols, Falls Prevention and Responsive Behaviours were also used during the inspection.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

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

5 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 provide direct care to the resident.

Resident #002 has been exhibiting responsive behaviors on several occasions since admission.

Resident #002 is followed by the Psychogeriatric Team on a monthly basis and by the Behavioral Support Personal Worker (PSW) on a weekly basis. The registered nursing staff and PSWs indicated that resident #002 does get agitated in a loud environment. Resident #002 will exhibit signs of agitation and if interventions are not implemented at that time, the behaviors will escalate and increase the risk of resident #002 exhibiting responsive behaviors.

During the course of this inspection, several Registered Nurses and Personal Support Workers were interviewed and were aware of the resident's triggers.

The plan of care was reviewed and it was noted that there was no documentation related to the triggers and responses to these triggers. The plan of care did not set out clear direction to staff and others who provided direct care related to the specific triggers of residents #002 (logs #013018-17, #007357-18, #025375-17). [s. 6. (1) (c)]

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

A complaint was submitted to the Director of the Ministry of Health and Long -Term Care related to unknown/ unexplained bruising on resident #001. The complainant was concerned about the resident's significant amount of multiple bruises.

On September 17, 2018, Inspector #573 reviewed resident #001's health care record (Wound/ Skin assessment and progress notes) for a month in 2018, which indicated:
- Day 3, resident #001 was observed with bruising.
- Day 6, resident #001's Substitute Decision Maker (SDM) was called to report bruising on resident. SDM was informed that the bruise was found last evening with unknown reason.
- Day 11, RN assessed resident #001 for bruising and swelling. RN also observed large bruising on resident. A physician referral was placed to reassess resident's bruising on two areas.
- Day 12, resident #001's SDM was informed that resident's suspicious bruising was assessed by the physician and ordered for blood work.
- Day 13, progress notes indicated that the resident's blood work indicated a specific parameter was low, had unexplained large bruises for one to two weeks. Further the progress notes indicated that physician was contacted, and resident #001 was transferred to the hospital for further management.

Inspector #573 reviewed resident #001's MDS assessment, which indicated that the resident required two person extensive assistance for transfers. A review of the written plan of care in place at the time of incident for transfers indicated that the resident required extensive assistance with two staff members for transfers.

On September 24, 2018, Inspector #573 spoke with PSW #101 who provided direct care to resident #001. PSW #101 stated to the inspector that resident #001 required extensive assistance for transfers by one staff member. Further, PSW #101 stated that they would place both their arms under the resident's shoulders and transfer the resident.

On September 25, 2018, Inspector #573 and RN #102 reviewed PSW documentation records for resident #001 transfers for a six week period. Upon review, it was observed that on 39 occasions, it was documented that resident #001 was transferred by one person physical assistance.

During an interview on September 25, 2018, RN #102 stated that resident #001's written plan of care at the time of incident indicated that resident required extensive assistance with two staff members for all transfers. Further, RN #102 indicated that PSW staff are to transfer resident #001 as per the written plan of care.

The plan of care regarding resident #001's transfers was not provided to the resident as specified in the plan (log #013378-18). [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in resident #004's plan of care was provided to the resident, as specified in the plan.

A complaint to the Director was received resident #004. Resident #004 indicated that there was an order for a treatment to a wound that was to be administered every three days, however this treatment was not being administered every three days as per the physicians order.

A review of resident #004's documented plan of care, indicated a wound on their body. Interventions included to document wound progression and appearance at each dressing change, follow course of treatment (see TAR). If resident refuses, reproach.

A review of resident #004's treatment administration record (TAR) found the following order:

Dressing can be changed by RPN
1. Cleansed the area with wound cleaner.
2. Apply a specific base cream to wound.
3. Apply a specific topical to wound.
4. Use pads and wrap with a specific dressing loosely.

One time a day every 3 day(s).

A review of the resident #004's TAR for a three month period, found the following dates where the dressing change was not completed:

* The reason in the TAR refers to the progress notes which document: Will inform evening staff dressing change required. There was no communication documented in the progress notes from the following shifts indicating whether the dressing had been changed. The TAR indicated that the next dressing change occurred six days since the

last dressing change.

* The reason in the TAR or progress notes was not indicated, there was no documented follow up from following shifts in the progress notes. The next dressing change occurred six days since the last dressing change.

* The TAR indicated that the resident refused. There was no communication documented in the progress notes from following shifts indicating whether the dressing had been changed. The dressing was not changed until six days since the last dressing change.

* The TAR indicated that the resident refused. There was no communication documented in the progress notes from following shifts indicating whether the dressing had been changed. The dressing was not changed until seven days since the last dressing change. After this day, the next scheduled dressing change was for three days later however this was not completed and the reason documented in the TAR was "dressing intact".

* The TAR indicated that the resident refused. There was no communication documented in the progress notes from following shifts indicating whether the dressing had been changed. As of this date, the dressing had not been changed for seven days.

A review of the nursing communications book found no entries related to the above dates where the dressing change was not completed.

During an interview with Inspector #593, on September 24, 2018, RPN #104 indicated that sometimes resident #004 does refuse to have their dressing changed, other times they are unable to change the dressing, as the specific dressings are sometimes unavailable and they are kept locked in the supply room, which the RPN does not have access to.

During an interview with Inspector #593, on September 24, 2018, RN #102 indicated that the wound dressing ideally needs to be changed every three days, but at a minimum, twice weekly. RN #102 added that if resident #004 refuses to have their dressing changed, then they should try again at the following shifts until the dressing has been changed.

During an interview with Inspector #593, on September 25, 2018, the Director of Care (DOC) indicated that if resident #004 refused to have their dressing changed, then the nurses need to go back and ask the resident again, they give the resident some time, if it

reaches the end of their shift and the nurses have been unable to change the residents dressing, they pass this onto the next shift. If the dressing has not been completed, this should be documented in the TAR or in the nursing communications book, so that the next shift is aware that the dressing change needs to be completed (log #028438-17). [s. 6. (7)]

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

Resident #010 was found to have a laceration from an unknown cause. Upon the completion of the investigation, it was determined that PSW #105 did not provide care to resident #010 as specified in the plan of care.

Resident #010 required extensive assistance for dressing, hygiene and toileting.

In the home's "Investigation Report", it was documented that resident #010 care plan stated the following: "Requires assistance for the physical process of toileting. TOILETING-extensive phys. assist for safety…Staff must remain with resident for entire process to ensure safety. Transfer on and off toilet using specific device. Transfer: Provide two person phys. Assist specific device."

During the investigation, PSW #105 indicated that on a specific day, resident #010 was transferred to the toilet without the assistance of a colleague and the resident was left alone on the toilet as PSW #105 left the bathroom area to get clean clothes for the resident. Upon returning to the bathroom, PSW #106 indicated that when they took off the resident shirt, they noticed resident #010 was bleeding.

As such, PSW #106 did not provide the care set out in the plan of care to ensure resident was a two person transfer and to ensure that during toileting PSW stayed with the resident for the entire process (logs #013018-17, #007357-18, #025375-17). [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the written plan of care for each resident sets out clear direction to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 the written staffing plan required under s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clause 31. (1) (a) the organized program of nursing services, and 31. (1) (b) the organized program of personal support services, was complied with.

Inspector #593 reviewed the home's Nursing and Personal Support Services Staffing Plan revised date February, 2015 on September 25, 2018. The following was documented in this plan:

3. Promoting Continuity of Care (page 2 of 2)

In keeping with Collective Agreements, the number of different staff members who

provide nursing and personal support services to each resident will be minimized by:

- Offering overtime to current full-time, part-time and casual staff, before using agency staff.

4. Back-up Plan for Nursing and Personal Care Staffing (page 2 of 2)

- Agency staff will be used as a last resort to address situations where nursing staff absences cannot be replaced by Ottawa Grace Manor nursing staff.

During an interview with Inspector #655, September 12, 2018, resident #005 indicated that the unit was often "short staffed" and that they often have many staff from agencies, and they do not know what they are doing. They do not answer the residents call bell or attach it to their pillow so it is within reach. The resident further indicated that this was a common occurrence.

During an interview with Inspector #593, on September 20, 2018, Scheduler staff member #105 indicated that the home have a group voice/text system to contact staff to replace vacant shifts. Staff member #105 further indicated that this was the first method they used to replace shifts, followed by calling staff individually, asking staff to work overtime, accessing the casual pool of staff and then finally, use of agency staff. This process was also to be followed when the Scheduler finished their shift at 1500 hours and the task is handed over to the charge RN. Staff member #105 added that the group voice/text system keeps a record of outgoing messages and so they can tell if the process has been followed for replacing shifts. Staff member #105 further explained that there was a payroll verification form that was to be completed for vacant shifts such as sick calls. This form is to be populated when replacing a shift and includes whether the auto text/voice messaging system has been used and who the shift is ultimately covered by. Staff member #105 indicated that this process was not always followed by the charge RN.

Staff member #105 provided the following payroll verification forms where the process was not followed for replacing a vacant shift:

September 16, 2018- shift replaced by agency staff
September 15, 2018- shift replaced by agency staff
September 10, 2018- shift replaced by agency staff
September 9, 2018- shift replaced by agency staff

During an interview with Inspector #593, on October 5, 2018, the DOC confirmed that the process reported by staff member #105 was correct and that the use of agency staff should only occur when regular staff have been offered the shift first (log #025324-18). [s. 8. (1) (b)]

2. The licensee failed to ensure that the home's policy "Falls Prevention and Management" was complied with.

According to O. Reg 79/10, s. 48 (1) 2, every licensee of a long-term care home shall ensure that the following interdisciplinary programs is developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

A review of the home's Falls Prevention and Management Policy #F23, revision date February 2015, item #1 and #8 under section Assessment 1.4 Fall prevention, indicated that the registered staff will:

Item #1: Conduct the fall risk assessment on admission, quarterly and when a change in health status increased resident's risk for falling such as:
- 2 falls in 72 hours
- More than 3 falls in 3 months
- More than 5 falls in 6 months
- Significant change in health status
- Fall resulting in serious injury

Item #8: Monitor and evaluate the care plan at least quarterly in collaboration with the interdisciplinary team. If the interventions have not been effective in reducing falls, initiate alternative approaches and update as necessary.

During this Inspection, Inspector #573 spoke with the RAI co-ordinator, who indicated that resident's fall risk assessment identifies the resident's fall risk level as Low, Moderate and High. Further, the RAI co-ordinator stated that according to the resident's fall risk level, the resident's care plan will be triggered for various fall prevention interventions.

A Critical Incident Report (CIR) #2873-000015-18 described an incident that caused an injury to resident #006 for which the resident was taken to hospital and that resulted in a

significant change in the resident's health status.

Resident #006 was admitted in the home with multiple diagnoses including history of falls. On September 17, 2018, Inspector #573 reviewed resident #006's health care record (progress notes) over a two month period and observed that since the time of admission resident #006 had sustained eight falls. The fall risk assessment which was completed at the time of admission indicated that resident #006 was at moderate risk for falls.

On a specific day, resident #006 was transferred to the hospital and diagnosed with multiple fractures. Several days later, resident #006 was transferred back to the facility. A review of resident #006's progress notes over a five month period, indicated that prior to the fall incident, resident #006 had three other fall incidents during this period.

Inspector #573 reviewed resident #006's health records. Upon review, the Inspector found that the fall risk assessment was not completed following the residents two falls within 72 hours and also upon the resident's significant change in health status.

A review of resident #006's progress notes indicated that prior to the fall incident, resident #006 was using a specific device for mobility.

On September 18, 2018, Inspector #573 reviewed resident #006's written plan of care for mobility at the time of the fall incident. Upon review, Inspector #573 observed that resident #006's written plan of care does not include the use of a specific device for the resident's mobility.

On September 18, 2018, Inspector #573 spoke with RPN #101, who indicated that on April 28, 2018, resident #006's SDM was contacted regarding the occupational therapist referral for the mobility aid process. RPN #101 also indicated to inspector that around the same time, resident #006's was provided with the home's loaner mobility device for mobility.

During an interview on September 19, 2018, the home's DOC indicated to the inspector that the registered nursing staffs were expected to complete fall risk assessments, as per the policy to identify the resident fall risk level, which helps in the implementation of fall prevention interventions. After a review of resident #006's health care records, the DOC indicated that fall risk assessment was not completed and the written plan of care regarding the use of a specific mobility device for resident #006's mobility was not

updated by the registered nursing staff as per the home's policy (log #010419-18). [s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint was submitted to the Director of the Ministry of Health and Long -Term Care related to unknown/ unexplained bruising on resident #001. The complainant was

concerned about the resident's significant amount of multiple bruises.

On September 17, 2018, Inspector #573 reviewed resident #001's health care record (Wound/ Skin assessment and progress notes) for a specific month, which indicated:
- Day 11, RN assessed resident #001 for bruising and swelling. RN also observed large bruising on resident's body. A physician referral was placed to reassess resident's bruising.
- Day 12, resident #001's SDM was informed that resident's suspicious bruising was assessed by the physician and ordered for blood work.
- Day 13, progress notes indicated that resident's blood work indicated a specific parameter was low, had unexplained large bruises. Further the progress notes indicated that physician was contacted, and resident #001 was transferred to the hospital for further management.

Inspector spoke with In-charge RN #103, who indicated that resident #001 was assessed for bruising and swelling. The RN stated to the Inspector that staff members on the unit were questioned related to resident's unexplained bruising. Further, RN #103 stated that a physician referral was placed to reassess resident's bruising.

On September 26, 2018, Inspector #573 spoke with the home's DOC, who stated that resident #001's unexplained bruising was reported by In-charge RN during morning shift report. The DOC indicated that an investigation was conducted related to the resident's bruising with the staff members and the DOC was unable to determine the cause of the bruising. Further, the DOC confirmed with the inspector that resident #001's unexplained bruising was not reported to the Director (log #013378-18). [s. 24. (1)]

2. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated; (i) Abuse of a resident by anyone.

On a specific day, resident #003 was heard yelling and when Registered Practical Nurse (RPN) #107 looked up, they observed resident #002 punching resident #003 in the face. Resident #003 was crying and was upset for a short time, some redness was observed to their face. Following the incident, Registered Nurse (RN) #108 immediately contacted the MOHLTC's Director to notify of the resident to resident physical abuse. A Critical Incident Form was submitted.

A discussion was held with Director Of Care (DOC) #100 who indicated that several

investigations have been conducted regarding alleged abuse in the home. At the time of the interview, the investigation notes were not available. Both residents' health care records were reviewed and no documentation was found related to an investigation conducted regarding that incident.

As such, an investigation was not immediately investigated regarding the indicated to resident to resident abuse (log #025375-17). [s. 24. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written staffing plan for the programs referred to in clause 31. (1) (a) the organized program of nursing services, and 31. (1) (b) the organized program of personal support services was evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices.

Inspector #593 reviewed the home's Nursing and Personal Support Services Staffing Plan on September 25, 2018. The last revised date was documented as February, 2015. The Director of Employee Relations confirmed that this was the most recent version of the staffing plan and indicated that it was not accurate to their current staffing schedule or requirements.

During an interview with Inspector #593, on September 26, 2018, the DOC indicated that they updated their staffing plan last year to include an additional 14 full-time positions. The DOC indicated that they would provide a copy of this staffing plan, however the documents provided were related to schedule changes and restructure. The documented staffing plan as discussed above was also provided with amendments, however this document was not dated, therefore it was unclear when this staffing plan was evaluated and updated. The date of this document was requested, however a response was never provided (log #025324-18). [s. 31. (3)]

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 ensuring that the staffing plan must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that when withholding approval for admission, the licensee shall give the persons described in subsection (10) a written notice setting out, a) the grounds or grounds on which the Licensee is withholding approval; b) a detailed explanation of the supporting facts, as they relate to both the home and to the applicant's condition and requirements for care; c) an explanation of how the supporting facts justify the decision to withhold approval; and d) contact information for the Director.

LTCHA 2007 stipulates in s. 44 (7) whereby the appropriate placement coordinator gave the Licensee copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the Licensee is to review these assessments and information and shall approve the applicants admission to the home unless, as the licensee specifies in their response letter that:

a) The home lacks the physical facilities necessary to meet the applicant's care requirements;

b) The staff of the home lack the nursing expertise necessary to meet the applicant's care requirements.

The written notice was provided to the applicant, as a letter by the licensee. In the letter, the Licensee did not provide detailed explanation of the supporting facts, as they related to the grounds for withholding approval for admission. It was not explained in the letter as to how the home a) lacked the physical facilities necessary to meet the applicant's care requirements or b) how the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements. The lack of explanation for withholding approval did not provide sufficient justification for the decision to withhold approval (log #011100-18). [s. 44. (9)]

Issued on this 5th day of December, 2018

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

Original report signed by the inspector.