Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 27, 2022	2022_834524_0001	015404-21, 015405-21, 015406-21, 015407-21, 015408-21, 015409-21, 015410-21, 015411-21, 016209-21, 016974-21, 016981-21, 017845-21, 018341-21	Critical Incident System

Licensee/Titulaire de permis

The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's
643 West Gore Street Stratford ON N5A 1L4

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

Spruce Lodge Home for the Aged
643 West Gore Street Stratford ON N5A 1L4

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

INA REYNOLDS (524), AMIE GIBBS-WARD (630), LOMA PUCKERIN (705241)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 5, 6, 7, 10, 11, 12, 13, 14, 17, 18 and 19, 2022.

The following Critical Incident System (CIS) intakes were completed within this inspection:
CIS # M575-000013-21 / Log # 016209-21 related to falls prevention and management
CIS # M575-000015-21 / Log # 016974-21 related to medication management
CIS # M575-000016-21 / Log # 016981-21 related to prevention of abuse and neglect
CIS # M575-000017-21 / Log # 017845-21 related to falls prevention and management
CIS # M575-000019-21 / Log # 018341-21 related to skin and wound care.

The following Follow-up intakes were completed within this inspection:
Log # 015404-21 follow-up to CO #001 related to clear directions on care plan
Log # 015405-21 follow-up to CO #002 related to providing care as per care plan
Log # 015406-21 follow-up to CO #005 related to bathing requirements
Log # 015407-21 follow-up to CO #004 related to investigation allegations of abuse and neglect
Log # 015408-21 follow-up to CO #006 related to turning and repositioning care
Log # 015409-21 follow-up to CO #007 related to continence care
Log # 015410-21 follow-up to CO #008 related to cleaning and disinfection of supplies and devices
Log # 015411-21 follow-up to CO #003 related to the abuse and neglect policy.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Life Enrichment Coordinator, the Human Resource Coordinator, the Infection Prevention and Control Program Lead, Registered Nurses/Team Leads, Registered Practical Nurses, a Public Health Inspector, Housekeeping staff, Personal Support Workers, family members and residents.

The inspector(s) also observed resident rooms and common areas, meal services, infection prevention and control practices within the home, residents and the care provided to them, reviewed clinical healthcare records and plans of care for identified residents, and relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **5 WN(s)**
- **3 VPC(s)**
- **2 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.O. 2007, c.8 s. 20. (1)	CO #003	2021_886630_0027	630
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #004	2021_886630_0027	630
O.Reg 79/10 s. 50. (2)	CO #006	2021_886630_0027	524
O.Reg 79/10 s. 51. (2)	CO #007	2021_886630_0027	630
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2021_886630_0027	630
O.Reg 79/10 s. 87. (2)	CO #008	2021_886630_0027	705241

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for identified residents was provided to them as specified in the plan for medication administration.

The licensee has failed to comply with Compliance Order (CO) #002 from Inspection #2021_886630_0027 served on September 17, 2021, with a compliance due date of December 10, 2021, related to the timing of medication administration for residents.

The residents' Point Click Care (PCC) plan of care included directions for medication administration for some residents. Staff were expected to administer the medications in accordance with the PCC plan of care, as well as the electronic Medication Administration Record (eMAR). The eMAR designated times for each medication, as well as special instructions for staff. Staff said medications were expected to be administered within one hour of the designated time.

Medication administration for residents was completed by a registered nursing staff who was responsible for the medication administration for three resident areas. This area covered between 35-40 residents per morning medication pass. Staff said it was difficult to administer medications to all residents in this area within the expected time frame, and often about a quarter of residents were not given their medications on time. The new Director of Care (DOC) said there had not been an audit completed of the medication administration times for this area.

A resident's plan of care included special instructions related to their medication. Based on observations and record review staff did not follow the resident's plan of care related to their medication. The new DOC identified that the special instructions were not followed at the time of the inspection.

On a specific day, a Registered Nurse (RN) arrived on a unit to complete the 0800 hours medication administration for residents in this area. The following was observed related to the timing of the prescribed 0800 hour medication administration:
- A resident was administered their medications almost 2 hours after the specified time.
- A resident was administered their medication over 2 hours after the specified time.
- The RN attempted to administer a resident their medications 2 and a half hours after the specified time, at which time the resident refused. There was no re-approach with the medications as per resident's plan of care.

The home's medication administration process for this area did not ensure medications were consistently being administered at the time and in a method specified in the residents' plans of care. This placed residents at risk for not receiving their medications in accordance with their clinical needs.

Sources: Observations; the eMAR for identified resident's and other clinical records; the home's "Medication Administration Pass" policy last revised August 2018; interview with a RN and other staff.
[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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that identified residents were bathed, at a minimum, twice a week by the method of their choice.

The licensee has failed to comply with Compliance Order (CO) #005 from Inspection #2021_886630_0027 served on September 17, 2021, with a compliance due date of October 31, 2021, related to bathing care.

Staff said there were times when baths were either missed entirely or bed baths were provided due to time constraints. Staff said there was a new process for making up missed baths in the home however, due to staffing levels and time restraints, this process did not consistently ensure residents received their preferred bathing care twice weekly. The new Director of Care (DOC) said further changes were needed to the bathing procedures, as well as the staffing plan, to accommodate these care needs.

Based on interviews and record reviews during the inspection, six identified residents were not provided their required bathing care.

Staff reported some residents were in precautionary isolation during part of this time, and they thought this meant they were to provide bed baths versus care in the tub room. The new DOC said they had identified that staff required new direction regarding Infection Prevention and Control (IPAC) practices for bathing care, to ensure residents who were in isolation were still offered bathing care in the tub room.

Due to the bathing care practices in the home, these residents were at risk for not receiving the personal bathing care they preferred and required.

Sources: Interview with residents; the residents' Point of Care (POC) documentation and other clinical records; the home's Bath Schedule; interview with a Personal Support Worker (PSW) and other staff. [s. 33. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian.

Review of a critical incident system (CIS) report submitted by the home and progress notes documented that a resident had areas of altered skin integrity.

A review of the resident's clinical records had no documented evidence that the resident had been referred to the Registered Dietitian (RD) for an assessment related to the altered skin condition.

The home’s Skin and Wound Care Program indicated that a resident was assessed by the dietitian when a resident exhibited skin breakdown and directed registered staff to make a referral to the interdisciplinary team members including the RD.

The Assistant Director of Care (ADOC) acknowledged that the RD was not sent a referral indicating a change in skin condition for the resident and a dietary assessment had not been completed. This placed residents at risk for not receiving potential changes needed to their nutrition and hydration plan of care.

Sources: The home's “Skin and Wound Care Program” Index #: RCM 2-2 (Revised date: August 2020); a Critical Incident System report; the resident’s clinical records; and, interviews with the ADOC and other staff. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that resident #003 who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

On January 5, 2022, at 1121 hours, Inspector #705421 observed the door to the Hopper room on West Haven unit propped open with a bottle of chemical with an unidentifiable label. On returning to the area at 1157 hours with Inspector #630 the door was still open. On January 6, 2022, at 1016 hours Inspector #705421 observed the door to the Hopper room on West Haven unit held open and a bottle of chemical on the floor.

On both occasions the open doors and visible chemicals were brought to the attention of staff members who closed the doors to the rooms. They said the products in the rooms could be potentially hazardous to residents.

The Material Safety Data Sheet (MSDS) for the product classified it as “skin corrosion/ irritation". The ADOC after conferring with the housekeeping manager said the doors to the hopper rooms were to be closed and the product in the rooms was hazardous material.

Sources: Observations January 5 and 6, 2022; the MSDS for Sure5 Germicidal detergent; interviews with the ADOC and other staff. [s. 91.]

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 all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program (IPAC) in accordance with the home's Hand Hygiene (HH) policy and with the Ontario evidence-based hand hygiene (HH) program, "Just Clean Your Hands"(JCYH) related to staff not performing HH before and after interactions within the residents' environment, before handling and serving food and when administering medications.

Inspector #630 observed staff members on an isolation wing in the home doubled gloved or wearing the same pair of gloves and not changing gloves during multiple interactions within the residents' environment.

Specifically, Inspector #630 observed a RPN wearing gloves while dispensing medications to multiple residents, then proceeding to access the medication cart and other items without changing the gloves or performing hand hygiene. During a fifty-minute time frame, the RPN checked residents' temperatures and had close interactions with many residents and did not change their gloves or perform hand hygiene. Also, observed was a PSW wearing two pairs of gloves. The PSW assisted with the meal service, feeding residents and cleared soiled dishes from tables and did not remove or change the gloves to perform hand hygiene. Furthermore, this staff member was witnessed wiping the gloves on their clothing and then serving food items to residents.

Again, on another day, the PSW was noted to be double gloved and was only removing the first pair, reapplying another and did not perform HH during the meal service. Other staff members were witnessed wearing the same pair of gloves clearing dirty bowls from tables, and no HH was performed before serving clean dishes with food from the servery or providing eating assistance to residents or touching residents. HH was not performed prior to donning and after doffing of gloves.

The home's HH policy indicated that it was based on the "4 Moments of Hand Hygiene" and stated HH was necessary for healthcare workers.

The IPAC Lead verified that staff should have performed HH prior to donning and after doffing gloves and that the expected process was that staff perform HH between residents.

The home's Public Health Inspector said double gloving was not recommended and hand hygiene should be done between all resident interactions.

There was potential risk to residents for the failure of the home's staff not performing HH as outlined within the home's HH policy. This area of the home was under droplet and contact precautions under the direction of the Public Health Unit (PHU) related to Covid-19 at the time of the inspection.

Sources: Observations; the home's Hand Hygiene Policy Index # II-3 issued December 2021; the JCYH Implementation Guide; interviews with the IPAC Lead and other staff; and, the home's Public Health Inspector. [s. 229. (4)]

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 all staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

Issued on this 27th day of January, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	INA REYNOLDS (524), AMIE GIBBS-WARD (630), LOMA PUCKERIN (705241)
Inspection No. / No de l’inspection :	2022_834524_0001
Log No. / No de registre :	015404-21, 015405-21, 015406-21, 015407-21, 015408-21, 015409-21, 015410-21, 015411-21, 016209-21, 016974-21, 016981-21, 017845-21, 018341-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 27, 2022
Licensee / Titulaire de permis :	The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's 643 West Gore Street, Stratford, ON, N5A-1L4
LTC Home / Foyer de SLD :	Spruce Lodge Home for the Aged 643 West Gore Street, Stratford, ON, N5A-1L4
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Peter Bolland

Ontario

Ministry of Long-Term Care

Ministère 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 Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_886630_0027, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the LTCHA.

Specifically, the licensee must:

-Ensure the care set out in the plan of care, including the Point Click Care (PCC) plan of care and electronic Medication Administration Record (eMAR), related to the timing of and method for medication administration is provided to identified residents, and every other resident in the home, as specified in their plan.

-Review and revise the medication administration process for the home to ensure it supports the administration of medications in accordance with the timing and methods specified in the residents' plans of care. A documented record of this review and revision must be maintained in the home.

-Develop and implement an auditing process for medication administration to ensure medications are being administered to residents in accordance with the timing and methods specified in the residents' plans of care. A documented record of this auditing must be maintained in the home. The auditing must continue until Compliance Order (CO) has been complied.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care for identified residents was provided to them as specified in the plan for medication administration.

The licensee has failed to comply with Compliance Order (CO) #002 from Inspection #2021_886630_0027 served on September 17, 2021, with a compliance due date of December 10, 2021, related to the timing of medication administration for residents.

The residents' Point Click Care (PCC) plan of care included directions for medication administration for some residents. Staff were expected to administer the medications in accordance with the PCC plan of care, as well as the electronic Medication Administration Record (eMAR). The eMAR designated times for each medication, as well as special instructions for staff. Staff said medications were expected to be administered within one hour of the designated time.

Medication administration for residents was completed by a registered nursing staff who was responsible for the medication administration for three resident areas. This area covered between 35-40 residents per morning medication pass. Staff said it was difficult to administer medications to all residents in this area within the expected time frame, and often about a quarter of residents were not given their medications on time. The new Director of Care (DOC) said there had not been an audit completed of the medication administration times for this area.

A resident's plan of care included special instructions related to their medication. Based on observations and record review staff did not follow the resident's plan of care related to their medication. The new DOC identified that the special instructions were not followed at the time of the inspection

On a specific day, a Registered Nurse (RN) arrived on a unit to complete the 0800 hours medication administration for residents in this area. The following was observed related to the timing of the prescribed 0800 hour medication administration:
- A resident was administered their medications almost 2 hours after the specified time.
- A resident was administered their medication over 2 hours after the specified time.
- The RN attempted to administer a resident their medications 2 and a half hours after the specified time, at which time the resident refused. There was no re-

approach with the medications as per resident's plan of care.

The home's medication administration process for this area did not ensure medications were consistently being administered at the time and in a method specified in the residents' plans of care. This placed residents at risk for not receiving their medications in accordance with their clinical needs.

Sources: Observations; the eMAR for identified resident's and other clinical records; the home's "Medication Administration Pass" policy last revised August 2018; interview with a RN and other staff.

An order was made by taking the following factors into account:

Severity: There was risk of harm because the identified residents did not receive care as specified in their plan of care.

Scope: Three of the five residents reviewed had issues with staff non-compliance with their plan of care, demonstrating a pattern.

Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 6 (7) of the LTCHA. This subsection was issued as a CO on September 29, 2021, during inspection #2021_886630_0027, with a compliance due date of December 10, 2021. In the past 36 months, ten other COs were issued to different sections of the legislation, eight of which have been complied.
(630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 25, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 # / No d'ordre : 002

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

Linked to Existing Order / Lien vers ordre existant: 2021_886630_0027, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with subsection s. 33. (1) of O. Reg. 79/10.

Specifically, the licensee must:

-Ensure that the identified residents, and every other resident in the home, is bathed, at a minimum, twice a week by their preferred method as identified in their plan of care.

-Re-assess the identified resident's responsive behaviours related to refusal of bathing care and their bathing preferences. Based on the assessment, develop and implement written care strategies as part of their bathing plan of care to meet their individual bathing care needs.

-Develop and implement an auditing process for bathing care to ensure care is being provided in accordance with the preferences in the residents' plans of care. A documented record of this auditing must be maintained in the home. The auditing must continue until Compliance Order (CO) has been complied.

Grounds / Motifs :

1. The licensee has failed to ensure that identified residents were bathed, at a minimum, twice a week by the method of their choice.

The licensee has failed to comply with Compliance Order (CO) #005 from

Inspection #2021_886630_0027 served on September 17, 2021, with a compliance due date of October 31, 2021, related to bathing care.

Staff said there were times when baths were either missed entirely or bed baths were provided due to time constraints. Staff said there was a new process for making up missed baths in the home however, due to staffing levels and time restraints, this process did not consistently ensure residents received their preferred bathing care twice weekly. The new Director of Care (DOC) said further changes were needed to the bathing procedures, as well as the staffing plan, to accommodate these care needs.

Based on interviews and record reviews during the inspection, six identified residents were not provided their required bathing care.

Staff reported some residents were in precautionary isolation during part of this time, and they thought this meant they were to provide bed baths versus care in the tub room. The new DOC said they had identified that staff required new direction regarding Infection Prevention and Control (IPAC) practices for bathing care, to ensure residents who were in isolation were still offered bathing care in the tub room.

Due to the bathing care practices in the home, these residents were at risk for not receiving the personal bathing care they preferred and required.

Sources: Interview with residents; the residents' Point of Care (POC) documentation and other clinical records; the home's Bath Schedule; interview with a Personal Support Worker (PSW) and other staff.

An order was made by taking the following factors into account:

Severity: There was risk of harm because the identified residents did not receive their preferred bathing care twice per week.

Scope: Six of six residents reviewed for bathing care had non-compliance, demonstrating a widespread issue.

Compliance History: A compliance order (CO) is being re-issued for the licensee

failing to comply with s. 33 (1) of O. Reg. 79/10. This subsection was issued as a CO on September 29, 2021, during inspection #2021_886630_0027, with a compliance due date of October 31, 2021. In the past 36 months, ten other COs were issued to different sections of the legislation, eight of which have been complied.
(630)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 25, 2022

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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 27th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ina Reynolds

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