Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 8, 2016	2015_320612_0020	026529-15	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road SUDBURY ON P3E 0B6

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

ST. JOSEPH'S VILLA, SUDBURY
1250 South Bay Road SUDBURY ON P3E 6L9

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

SARAH CHARETTE (612), SYLVIE BYRNES (627)

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): October 14, 15 and 16, 2015.

This Complaint Inspection is related to 6 complaints received by the Ministry regarding the Home being short staffed personal support workers (PSW) and care not being provided to residents as required.

During the course of the inspection, the inspector(s) spoke with Residents, the Scheduling Clerk, the Admission Coordinator, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Director of Care (DOC) and the Administrator.

Throughout the inspection, the inspector observed the delivery of care and services to residents, reviewed residents' health care records, reviewed staffing sign-in sheets and reviewed various policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Responsive Behaviours
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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home that met the assessed needs of the residents.

Inspector #612 and #627 inspected six complaint logs received by the ministry which reported that the home was short staffed and care was not being provided to the residents. During the course of the inspection, the inspectors were approached by additional family members and residents who expressed concerns about the home being short staffed and the care needs of residents not being met.

i) Inspector #627 observed a supper dining service on one of the units in the home. The Inspector observed resident #011 put food in their mouth and spit it out throughout the meal. Resident #011 did not swallow any of their meal. No staff assisted resident #011 with their meal.

Inspector #627 reviewed resident #011's care plan which stated that the resident required physical assistance of one staff for feeding and to cue resident to swallow their food.

Inspector #627 interviewed staff #107 and RN #106, who confirmed that resident #011 required assistance of staff for feeding however the unit was short staffed.

Inspector #627 reviewed the home's staffing policy, dated August 8, 2014 and noted that a particular unit should have had five PSWs during the evening shift.

An interview with staff #112 confirmed that on that date, there was only three PSWs on the unit.

ii) Inspector #612 interviewed PSW #103 and RPN #102 who stated that the home was often short staffed on the night shift. They stated that during the night shift, there is one PSW scheduled on each unit and two float PSWs, for a total of six PSWs in the building. PSW #103 and RPN #102 stated that when they are short PSWs on night shift, residents wait longer for care.

Inspector #627 interviewed PSW #104 who confirmed that night shift was often short staffed. On nights when they are short PSWs the remaining PSWs and registered staff are required to coordinate to ensure that breaks are covered and personal care is completed, however the reality is that a unit may be left without any staff and resident care is not completed. PSW #104 reported specific dates that the home was short staffed

PSWs.

A review of the home's staffing policy, dated August 8, 2014, revealed that the home should have 6 PSWs on duty during the night shift. Inspector reviewed the staff sign-in sheets for the night shifts reported by PSW #104 and noted the home was short one to two PSWs in the home.

iii) Inspector #627 interviewed resident #010. Resident #010 stated that the home was consistently short staffed. Resident #010 stated that they needed the assistance from one staff for toileting. Resident reported that they had often waited 10 to 30 minutes before a PSW was available to assist them. Resident reported that the the home was short on a specific date, which resulted in them being incontinent twice.

Inspector #627 reviewed the staff sign-in sheets with staff #112 for the date specified by resident #010 and confirmed that the home was short one PSW on day shift and three on evening shift. The home was short one PSW on resident #010's unit.

Inspector #612 reviewed resident #010's call bell report with the Director of Care and Administrator on October 16, 2015. They stated that the target response time for a call from the lavatory was two minutes and from the resident's room four minutes.
- 35% of resident #010's calls exceeded the home's target response time
- Resident #010 made up 8.5% of the calls on the unit from September 1 to Oct 14, 2015.
- Maximum response time for resident #010's calls was 25 minutes and 18 seconds.

iv) Inspector #627 interviewed resident #003's family member who stated that they visit the home most nights. The family member stated they felt the home was always short staffed and they worried that resident #003 was not receiving the care they required. The family member expressed that they felt the staff expected them to provide some care to the resident and were concerned that the resident would not receive the care if they did not come. The family expressed that they spend as much time as possible at the home.

On October 14, 2015 Inspector #627 observed RPN #108 feed resident #003 two spoonfuls of food, while in a standing position, then left to assist other residents. Resident #003 was not assisted with their food again until their family member arrived. Inspector #627 observed that the unit was short two PSWs during the dinner service; this was confirmed by RN #106.

The family member of resident #003 mentioned on specific dates, when they arrived in the home, they noted that resident #003 had not been provided specific care.

Inspector #627 reviewed the staff sign-in sheet with staff #112. They confirmed that on one of the dates specified by the family member, the unit that resident #003 resides on, was short two PSWs during the day shift and one PSW during the evening shift. On another date mentioned, the home was short two float PSWs during night shift. On another date, resident #003's unit was short one PSW during the day shift and one PSW during the evening shift. And the final date mentioned, resident #003's unit was short one PSW during the day shift.

The family reported that they noted resident #003 often smelt strongly of urine and that they felt resident #003 was not being bathed however staff reported to the family, that the resident was always bathed.

Inspector #627 reviewed resident #003's clinical records and noted one date that the resident had not received their scheduled bath. On the same day it was documented that the resident had not received their scheduled bath 'due to lack of staff'. According to the daily staff sign in sheet the home was short three PSWs on the evening shift in the home, one PSW specifically on the unit where resident #003 resided.

v) Inspector #627 interviewed a family member of resident #007. The family member verbalized multiple concerns regarding the home being short staffed. The family member reported that on a specific date when they arrived on resident #007's unit, they found resident #007 was still in bed and no morning care had been provided. When the family member asked a staff member why this had occurred, the staff member lifted three fingers to indicate they were short staffed, with only three PSWs on the unit. The family member provided morning care to resident #007 which included getting them dressed and bringing them to the dining room.

Inspector #627 reviewed the daily staff sign-in sheet with staff #112 and they confirmed that the unit resident #007 resided on was short one PSW on the date in question.

The family member of resident #007 reported to Inspector #627 on another day they arrived at the home in the afternoon and found resident #007 sitting in the dining room in a wheelchair. When the family member inquired why this was, they were told by PSW #111 that this was because they were short staffed and could not watch the resident.

Inspector #627 reviewed the daily staff sign-in sheets with staff #112 and confirmed that the unit that the resident resided on was short two PSWs during the evening shift on the date in question.

Inspector #612 reviewed resident #007’s plan of care and noted that the resident required supervision by one staff for walking and that resident was to be in the wheelchair only during the nightshift for safety reasons.

Inspector #612 interviewed PSW #114 who confirmed that the wheelchair is used during the night shift for the resident’s safety. At all other times, staff will walk with resident #007 therefore the wheelchair was not used.

The same family member verbalized concerns about staffing levels during the weekend. They felt this was when the home was most short staffed and falls were increased. The family member expressed on a specific date they had received five calls regarding multiple falls resident #007 had during the day. The family member felt that this was due to new staff that were rushed and did not know the resident’s plan of care.

Inspector #627 reviewed resident #007’s clinical records and noted they had three falls documented for the specific date.

As per the home’s staff sign-in sheets which were reviewed with staff #118, the unit the resident resided on was short one PSW during the day shift and one float PSW during the night shift. Staff #118 stated the same date, there was one full time PSW and one part time PSW working on the unit. The other PSWs were in casual or float positions.

vi) Inspector #627 interviewed a family member of resident #009. The family member stated that they are increasingly concerned regarding staffing levels and they felt that resident #009’s care was impacted. They stated that a family member who was visiting resident #009 on a specific date noted that PSW #110 had bathing supplies and resident’s pyjamas ready. When the family member stated that it was not reasonable to have resident in pyjamas for dinner when all the other residents were dressed, PSW #110 responded that they would not have time to bathe them after dinner without help. The family member agreed to assist PSW #110 to bathe the resident later in the evening.

Inspector #627 reviewed the daily staff sign-in sheets for the date in question with staff #112. They confirmed that the home was short one PSW during the evening shift on

resident #009’s unit.

According to another family member of resident #009, they were asked by PSW #109 if the family member could assist with the bath as they were short staffed and PSW #109 was not familiar with the resident’s care needs. Another staff member, PSW #110, told PSW #109 and the family member, that they did not have time to assist PSW #109 due to their own workload and the unit being short staffed. The family member assisted with bathing resident #009 but told Inspector #627 that they found this was difficult for them. The family member stated that they were concerned as well as resident #009 is often put to bed for the night too early due to a lack of staff. When Inspector #627 asked resident #009 if going to bed so early concerned them, resident #009 replied that they did not feel comfortable bringing a complaint forward.

As per the daily staff sign-in sheets, the unit that resident #009 resided on was short one PSW during the evening shift on the date in question.

vii) Inspector #612 was on a specific unit during shift change, day shift to evening shift. Inspector was at the nurses’ station and all staff on the evening shift were in the nurses’ report room which prevented them from visualizing residents on the unit. The day shift PSWs had left the unit. The day shift RPN was in the medication room.

Inspector #612 observed during this time, resident #013 began to exhibit responsive behaviours. Resident #013 was in the dining room and other residents and family members were present. Inspector alerted the day shift RPN #116, who was getting ready to leave the unit, however they were unable to redirect the resident. RPN #116 went to get the evening shift staff from the report room however they were not finished their report. RPN #116 stated to the Inspector that resident #013 does this all the time and then left the unit. PSW #114, a day shift PSW, returned to the unit to retrieve something, noticed resident #013 and proceeded to assist resident #013 and direct them to their room to provide care.

At approximately 1510hrs Inspector heard a bang from the other side of the nurses’ station and observed that resident #014 was on the floor. All day shift staff had left the unit at this time and there was no staff out on the unit. The evening shift staff had not completed their report and they remained in the report room. Inspector knocked on the door of the report room to notify the staff of the resident’s fall.

Resident #010, and the family members of residents on the unit that Inspector #612 was

on, expressed during interviews, that during shift changes, residents are not supervised and staff are unavailable. Multiple staff confirmed that they conduct report in the report rooms and it takes approximately five to fifteen minutes and during this time, there are no staff on the unit.

viii) Inspector #627 reviewed the Residents’ Council Meeting minutes from June, 2015, August, 2015 and September, 2015. Inspector noted that during the three meetings, concerns about the home being short staffed PSWs and resident care not being completed, was raised by the Council. The response from the Administrator was that all PSW positions were filled and sick calls were being replaced as possible. The home was implementing an attendance management system.

Inspector #612 interviewed the Administrator and the Director of Care and they confirmed that staffing was an issue in the home but stressed that resident care was the priority. [s. 8. (1) (b)]

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

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or

staff through observation, which could potentially trigger such altercations.

Inspector #612 and #627 received multiple complaints from family members on a specific unit in regards to resident #012’s responsive behaviours. The family members expressed that resident #012 had been physically responsive with residents #009, #008, #007 as well as other residents on the unit. The families also reported that they had witnessed resident #012 be physically responsive with staff on the unit.

On Oct 15, 2015, Inspector #612 observed resident #012 sitting at the table with co-resident #007 in the dining room. Resident #007 was pushing the table that was between them back and forth. Inspector observed resident #012 exhibiting responsive behaviours directed at resident #007. RPN #116 was in the dining room and observed resident #012 become increasingly agitated however did not separate the residents or intervene in any way. Resident #012 continued to be agitated until PSW #114 entered the dining room approximately 10 minutes after and removed resident #007. Resident #012 then settled.

Inspector #612 reviewed resident #012’s clinical records. Inspector noted that there were almost daily instances of resident exhibiting verbally and physically responsive behaviours towards other residents and staff.

Inspector #612 reviewed resident #012’s plan of care which stated that resident had physically responsive behaviours.

The interventions listed in resident #012’s plan of care included the following:
- Attempt to divert attention from the situation by walking away and returning with a different, smiling approach, changing the activity/offering food or drink
- Move out of range of resident when physically responsive behaviours occur or are anticipated
- When becoming responsive, remove resident to a quiet area and spend 1:1 time acknowledging feelings and providing reassurance, if safe to do so.

Inspector #612 was unable to locate any focus, goals or interventions related to resident’s verbally responsive behaviours or how staff can protect other residents on the unit from resident #012's physically responsive behaviours.

An interview with the Director of Care confirmed that resident #012’s responsive behaviours had not been assessed and no referrals to outside sources had been completed, therefore no steps has been taken to minimize the risk of potentially harmful

interactions between and among residents. [s. 54. (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.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 was provided to the resident as specified in the plan.

Inspector #612 reviewed resident #007's plan of care over a one month period and noted that resident had seven documented falls.

Inspector #612 reviewed resident #007's plan of care and noted that staff were to apply hip protectors as resident was at high risk for falls.

Inspector #612 reviewed resident #007's clinical record related to application of hip protectors and noted that over a one month time frame, when resident experienced seven falls, staff checked yes for the application of the hip protectors on two day shifts, however for all the other days it was documented not applicable or not applied.

Inspector #612 interviewed PSW #114 who stated that resident #007 does not have hip protectors available and hasn't for a long time.

Inspector #612 interviewed the Director of Care who confirmed that staff were not applying the hip protectors as per the plan of care. [s. 6. (7)]

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

Inspector #612 was on a specific unit during shift change day shift to evening shift. Inspector observed that resident #013 began to exhibit responsive behaviours. Resident #013 was in the dining room and other residents and family members were present. Inspector alerted the day shift RPN #116, who was getting ready to leave the unit however they were unable to redirect the resident. RPN #116 went to get the evening shift staff from the report room however they were not finished their report. RPN #116 stated to the Inspector that resident #013 does this all the time and then left the unit. PSW #114, a day shift PSW, returned to the unit to retrieve something, noticed resident #013 and proceeded to assist resident #013 and direct them to their room to provide care.

Inspector reviewed resident #013's plan of care which indicated a specific intervention to prevent resident from exhibiting this responsive behaviour.

Inspector interviewed PSW #114 who confirmed that for the resident, staff typically utilize this intervention however they were not able to as the required supply was not available.

Inspector interviewed the Administrator who confirmed that the staff did not provide care as per the plan of care. [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 to ensure that residents #007 and #013 are provided care as set out in their plans of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to minimize restraining of residents was complied with.

Inspector #612 observed resident #009 on a specific date with a restraining device.

Inspector reviewed resident #009's clinical record and was unable to locate any documentation related to reassessing the resident's condition and the effectiveness of the restraining device.

Inspector interviewed RPN #123 who stated that the registered staff do not complete any documentation every eight hours related to the resident's restraining device.

Inspector interviewed the Director of Care who confirmed that the registered staff are responsible to complete documentation in the resident's medication administration record (MAR) every 8 hours related to reassessing the resident's condition and the effectiveness of the restraining device.

A review of the home's Least Restraint Policy revealed that a member of the registered nursing staff will reassess the resident’s condition and the effectiveness of restraining at least every 8 hours while the restraint is in use. This will be documented in the MAR. [s. 29. (1) (b)]

Issued on this 19th day of January, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAH CHARETTE (612), SYLVIE BYRNES (627)
Inspection No. / No de l'inspection :	2015_320612_0020
Log No. / Registre no:	026529-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 8, 2016
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH CENTRE OF SUDBURY 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	ST. JOSEPH'S VILLA, SUDBURY 1250 South Bay Road, SUDBURY, ON, P3E-6L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gloria Richer

To ST. JOSEPH'S HEALTH CENTRE OF SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with the LTCHA, 2007 S.O 2007, s. 8. (1) (a) (b).

The plan must include:

- How the home will ensure that there is an adequate number of PSWs to meet the needs of all residents at all times, for all shifts and on all units.

- A review of the home's current base deployment of PSWs for all shifts to ensure that there is sufficient PSW staff so that all residents' needs are met.

- A review of the home's current process for shift to shift report on all units to ensure that there is staff coverage on the units at all times.

- Who will be responsible to review and assess the staffing complement, going forward, for all shifts and all units and how often this will be completed, to ensure the needs of the residents are met.

Please submit the plan, in writing, to Sarah Charette, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, via fax 705-564-3133 or by email at sarah.charette@ontario.ca, by January 15, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home that met the assessed needs of the residents.

Inspector #612 and #627 inspected six complaint logs received by the ministry which reported that the home was short staffed and care was not being provided to the residents. During the course of the inspection, the inspectors were approached by additional family members and residents who expressed concerns about the home being short staffed and the care needs of residents not being met.

i) Inspector #627 observed a supper dining service on one of the units in the home. The Inspector observed resident #011 put food in their mouth and spit it out throughout the meal. Resident #011 did not swallow any of their meal. No

staff assisted resident #011 with their meal.

Inspector #627 reviewed resident #011's care plan which stated that the resident required physical assistance of one staff for feeding and to cue resident to swallow their food.

Inspector #627 interviewed staff #107 and RN #106, who confirmed that resident #011 required assistance of staff for feeding however the unit was short staffed.

Inspector #627 reviewed the home's staffing policy, dated August 8, 2014 and noted that a particular unit should have had five PSWs during the evening shift.

An interview with staff #112 confirmed that on that date, there was only three PSWs on the unit.

ii) Inspector #612 interviewed PSW #103 and RPN #102 who stated that the home was often short staffed on the night shift. They stated that during the night shift, there is one PSW scheduled on each unit and two float PSWs, for a total of six PSWs in the building. PSW #103 and RPN #102 stated that when they are short PSWs on night shift, residents wait longer for care.

Inspector #627 interviewed PSW #104 who confirmed that night shift was often short staffed. On nights when they are short PSWs the remaining PSWs and registered staff are required to coordinate to ensure that breaks are covered and personal care is completed, however the reality is that a unit may be left without any staff and resident care is not completed. PSW #104 reported specific dates that the home was short staffed PSWs.

A review of the home's staffing policy, dated August 8, 2014, revealed that the home should have 6 PSWs on duty during the night shift. Inspector reviewed the staff sign-in sheets for the night shifts reported by PSW #104 and noted the home was short one to two PSWs in the home.

iii) Inspector #627 interviewed resident #010. Resident #010 stated that the home was consistently short staffed. Resident #010 stated that they needed the assistance from one staff for toileting. Resident reported that they had often waited 10 to 30 minutes before a PSW was available to assist them. Resident reported that the the home was short on a specific date, which resulted in them being incontinent twice.

Inspector #627 reviewed the staff sign-in sheets with staff #112 for the date specified by resident #010 and confirmed that the home was short one PSW on day shift and three on evening shift. The home was short one PSW on resident #010's unit.

Inspector #612 reviewed resident #010's call bell report with the Director of Care and Administrator on October 16, 2015. They stated that the target response time for a call from the lavatory was two minutes and from the resident's room four minutes.
- 35% of resident #010's calls exceeded the home's target response time
- Resident #010 made up 8.5% of the calls on the unit from September 1 to Oct 14, 2015.
- Maximum response time for resident #010's calls was 25 minutes and 18 seconds.

iv) Inspector #627 interviewed resident #003's family member who stated that they visit the home most nights. The family member stated they felt the home was always short staffed and they worried that resident #003 was not receiving the care they required. The family member expressed that they felt the staff expected them to provide some care to the resident and were concerned that the resident would not receive the care if they did not come. The family expressed that they spend as much time as possible at the home.

On October 14, 2015 Inspector #627 observed RPN #108 feed resident #003 two spoonfuls of food, while in a standing position, then left to assist other residents. Resident #003 was not assisted with their food again until their family member arrived. Inspector #627 observed that the unit was short two PSWs during the dinner service; this was confirmed by RN #106.

The family member of resident #003 mentioned on specific dates, when they arrived in the home, they noted that resident #003 had not been provided specific care.

Inspector #627 reviewed the staff sign-in sheet with staff #112. They confirmed that on one of the dates specified by the family member, the unit that resident #003 resides on, was short two PSWs during the day shift and one PSW during the evening shift. On another date mentioned, the home was short two float PSWs during night shift. On another date, resident #003's unit was short one

PSW during the day shift and one PSW during the evening shift. And the final date mentioned, resident #003's unit was short one PSW during the day shift.

The family reported that they noted resident #003 often smelt strongly of urine and that they felt resident #003 was not being bathed however staff reported to the family, that the resident was always bathed.

Inspector #627 reviewed resident #003's clinical records and noted one date that the resident had not received their scheduled bath. On the same day it was documented that the resident had not received their scheduled bath 'due to lack of staff'. According to the daily staff sign in sheet the home was short three PSWs on the evening shift in the home, one PSW specifically on the unit where resident #003 resided.

v) Inspector #627 interviewed a family member of resident #007. The family member verbalized multiple concerns regarding the home being short staffed. The family member reported that on a specific date when they arrived on resident #007's unit, they found resident #007 was still in bed and no morning care had been provided. When the family member asked a staff member why this had occurred, the staff member lifted three fingers to indicate they were short staffed, with only three PSWs on the unit. The family member provided morning care to resident #007 which included getting them dressed and bringing them to the dining room.

Inspector #627 reviewed the daily staff sign-in sheet with staff #112 and they confirmed that the unit resident #007 resided on was short one PSW on the date in question.

The family member of resident #007 reported to Inspector #627 on another day they arrived at the home in the afternoon and found resident #007 sitting in the dining room in a wheelchair. When the family member inquired why this was, they were told by PSW #111 that this was because they were short staffed and could not watch the resident.

Inspector #627 reviewed the daily staff sign-in sheets with staff #112 and confirmed that the unit that the resident resided on was short two PSWs during the evening shift on the date in question.

Inspector #612 reviewed resident #007's plan of care and noted that the resident

required supervision by one staff for walking and that resident was to be in the wheelchair only during the nightshift for safety reasons.

Inspector #612 interviewed PSW #114 who confirmed that the wheelchair is used during the night shift for the resident's safety. At all other times, staff will walk with resident #007 therefore the wheelchair was not used.

The same family member verbalized concerns about staffing levels during the weekend. They felt this was when the home was most short staffed and falls were increased. The family member expressed on a specific date they had received five calls regarding multiple falls resident #007 had during the day. The family member felt that this was due to new staff that were rushed and did not know the resident's plan of care.

Inspector #627 reviewed resident #007's clinical records and noted they had three falls documented for the specific date.

As per the home's staff sign-in sheets which were reviewed with staff #118, the unit the resident resided on was short one PSW during the day shift and one float PSW during the night shift. Staff #118 stated the same date, there was one full time PSW and one part time PSW working on the unit. The other PSWs were in casual or float positions.

vi) Inspector #627 interviewed a family member of resident #009. The family member stated that they are increasingly concerned regarding staffing levels and they felt that resident #009's care was impacted. They stated that a family member who was visiting resident #009 on a specific date noted that PSW #110 had bathing supplies and resident's pyjamas ready. When the family member stated that it was not reasonable to have resident in pyjamas for dinner when all the other residents were dressed, PSW #110 responded that they would not have time to bathe them after dinner without help. The family member agreed to assist PSW #110 to bathe the resident later in the evening.

Inspector #627 reviewed the daily staff sign-in sheets for the date in question with staff #112. They confirmed that the home was short one PSW during the evening shift on resident #009's unit.

According to another family member of resident #009, they were asked by PSW #109 if the family member could assist with the bath as they were short staffed

and PSW #109 was not familiar with the resident's care needs. Another staff member, PSW #110, told PSW #109 and the family member, that they did not have time to assist PSW #109 due to their own workload and the unit being short staffed. The family member assisted with bathing resident #009 but told Inspector #627 that they found this was difficult for them. The family member stated that they were concerned as well as resident #009 is often put to bed for the night too early due to a lack of staff. When Inspector #627 asked resident #009 if going to bed so early concerned them, resident #009 replied that they did not feel comfortable bringing a complaint forward.

As per the daily staff sign-in sheets, the unit that resident #009 resided on was short one PSW during the evening shift on the date in question.

vii) Inspector #612 was on a specific unit during shift change, day shift to evening shift. Inspector was at the nurses' station and all staff on the evening shift were in the nurses' report room which prevented them from visualizing residents on the unit. The day shift PSWs had left the unit. The day shift RPN was in the medication room.

Inspector #612 observed during this time, resident #013 began to exhibit responsive behaviours. Resident #013 was in the dining room and other residents and family members were present. Inspector alerted the day shift RPN #116, who was getting ready to leave the unit, however they were unable to redirect the resident. RPN #116 went to get the evening shift staff from the report room however they were not finished their report. RPN #116 stated to the Inspector that resident #013 does this all the time and then left the unit. PSW #114, a day shift PSW, returned to the unit to retrieve something, noticed resident #013 and proceeded to assist resident #013 and direct them to their room to provide care.

At approximately 1510hrs Inspector heard a bang from the other side of the nurses' station and observed that resident #014 was on the floor. All day shift staff had left the unit at this time and there was no staff out on the unit. The evening shift staff had not completed their report and they remained in the report room. Inspector knocked on the door of the report room to notify the staff of the resident's fall.

Resident #010, and the family members of residents on the unit that Inspector #612 was on, expressed during interviews, that during shift changes, residents

are not supervised and staff are unavailable. Multiple staff confirmed that they conduct report in the report rooms and it takes approximately five to fifteen minutes and during this time, there are no staff on the unit.

viii) Inspector #627 reviewed the Residents' Council Meeting minutes from June, 2015, August, 2015 and September, 2015. Inspector noted that during the three meetings, concerns about the home being short staffed PSWs and resident care not being completed, was raised by the Council. The response from the Administrator was that all PSW positions were filled and sick calls were being replaced as possible. The home was implementing an attendance management system.

Inspector #612 interviewed the Administrator and the Director of Care and they confirmed that staffing was an issue in the home but stressed that resident care was the priority.

The decision to issue this order was based on the scope which was widespread throughout the home and the severity was determined to be potential for actual harm to the safety and well-being of the residents of the home. A written notification was issued during the Resident Quality Inspection, in 2015, inspection number 2015_282543_0003. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between resident #012 and other residents including the following:

1) Complete a comprehensive assessment of resident #012 related to their responsive behaviours.

2) Review and update resident #012's plan of care based on the assessment and ensure that the plan of care is implemented.

3) Provide education to all staff related to the Home's Responsive Behaviour Program with a focus on the management of resident #012 and all residents who display responsive behaviours.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, which could potentially trigger such altercations.

Inspector #612 and #627 received multiple complaints from family members on

a specific unit in regards to resident #012's responsive behaviours. The family members expressed that resident #012 had been physically responsive with residents #009, #008, #007 as well as other residents on the unit. The families also reported that they had witnessed resident #012 be physically responsive with staff on the unit.

On Oct 15, 2015, Inspector #612 observed resident #012 sitting at the table with co-resident #007 in the dining room. Resident #007 was pushing the table that was between them back and forth. Inspector observed resident #012 exhibiting responsive behaviours directed at resident #007. RPN #116 was in the dining room and observed resident #012 become increasingly agitated however did not separate the residents or intervene in any way. Resident #012 continued to be agitated until PSW #114 entered the dining room approximately 10 minutes after and removed resident #007. Resident #012 then settled.

Inspector #612 reviewed resident #012's clinical records. Inspector noted that there were almost daily instances of resident exhibiting verbally and physically responsive behaviours towards other residents and staff.

Inspector #612 reviewed resident #012's plan of care which stated that resident had physically responsive behaviours.

The interventions listed in resident #012's plan of care included the following:
- Attempt to divert attention from the situation by walking away and returning with a different, smiling approach, changing the activity/offering food or drink
- Move out of range of resident when physically responsive behaviours occur or are anticipated
- When becoming responsive, remove resident to a quiet area and spend 1:1 time acknowledging feelings and providing reassurance, if safe to do so.

Inspector #612 was unable to locate any focus, goals or interventions related to resident's verbally responsive behaviours or how staff can protect other residents on the unit from resident #012's physically responsive behaviours.

An interview with the Director of Care confirmed that resident #012's responsive behaviours had not been assessed and no referrals to outside sources had been completed, therefore no steps has been taken to minimize the risk of potentially harmful interactions between and among residents.

The decision to issue this order was based on the severity as there is actual risk to other residents on the unit and scope which was determined to be widespread as it affected all residents on the unit. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 8th day of January, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Sarah Charette

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