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

Central East Service Area Office
33 King Street West, 4th Floor
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 05, 2021	2019_603194_0022 (A3)	010330-19, 013264-19, 013911-19, 015327-19, 017366-19, 018913-19, 018962-19	Complaint

Licensee/Titulaire de permis

Trent Valley Lodge Limited
195 Bay Street Trenton ON K8V 1H9

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

Trent Valley Lodge
195 Bay Street Trenton ON K8V 1H9

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

Amended by DENISE BROWN (626) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date changed to February 28, 2021 as requested by the licensee and directed by the SAOM.

Issued on this 5 th day of January, 2021 (A3)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by DENISE BROWN (626) - (A3)

Amended 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 1,2,3,4,7,8,10,15,16,17,18 and 21, 2019

Inspectors inspected the following:

Log # 010330-19, follow up inspection for CO#001, related to staffing.

Log # 018913-19, complaint, related to staffing and a fall.

Log # 013911-19, complaint, related to resident care.

Log # 013264-19, complaint, related to resident care and laundry.

Log # 015327-19, complaint, related to resident care.

Log # 017366-19, complaint, related to staffing and communication system.

Log # 018962-19, complaint, related to staffing and resident care.

During the course of the inspection, the inspector(s) spoke with Residents, Licensee, Administrator, Director of Care (DOC), Clinical Care Co-ordinator (CCC), Nurse Manager, Unit/payroll clerk, Support Services Manager (SSM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activity Aide and Dietary Aide.

Inspectors reviewed the PSW master staffing plans, back up plans, time-sheets, staffing logs, sickness/absence reports, call- in sheets, Low staffing protocol forms, complaint binder, clinical health records for identified residents, policies related to falls, complaints, and laundry. Inspectors observed the provision of nourishment cart, resident lounge area and the staff to resident provision of care.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Personal Support Services
Responsive Behaviours
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **1 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 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 failed to provide a PSW staffing mix that was consistent with the resident's assessed continence care needs.

A compliance Order (CO) #001 was issued to the licensee on May 14, 2019, under O. Reg 79/10, s. 31(3) within report # 2019_603194_0009 with a compliance date of July 17, 2019. On July 15, 2019 the licensee requested an extension of the compliance due date, which was granted and extended to September 17, 2019. On September 09, 2019 the licensee requested a further extension of the compliance due date, which was not granted. The licensee had been previously issued CO #002, under the same legislation on January 16, 2019 with report # 2018_603194_0019 with a compliance date of March 4, 2019.

On May 14, 2019 the licensee was ordered to:
-provide a staffing mix that is consistent with the residents assessed care and safety needs.
-ensure that the residents are bathed, at a minimum twice weekly by the method of their choice.
-ensure that residents are provided continence care according to their assessed

care needs, specifically residents who required two staff assistance for continence care.

During an interview with Inspector #194, the Administrator verified that the home's census was 121 beds. The Administrator provided the inspector with the current PSW staffing plans and explained that due to budgetary commitments a reduction in PSW staffing would be in effect October 01, 2019.

Inspector #194 verified the PSW staffing in the home by reviewing the PSW schedules for a specified period. The PSW schedules indicated that there were a total of 48 (8 hour shifts) and 55.5 hours that the home had not been able to fill during the reviewed period.

Review of the resident census and PSW staffing plan in the home, after October 1, 2019, indicated no change to the resident census and the staffing plan indicated that two float positions were removed.

Inspector #194 verified the PSW staffing in the home by reviewing the PSW schedules for an other specified period. The PSW schedules indicated that there were a total of 29 (8 hour shifts) and 22 PSW hours that the home had not been able to fill during the reviewed period.

An interview with the DOC indicated there were a specified number full-time, permanent part-time and casual PSWs currently employed at the home. The DOC indicated there is a high number of leave of absences (LOA) in the home contributing schedule vacancies. The DOC further indicated that hiring for vacant LOA positions has been difficult, as no permanent positions can be offered. The DOC confirmed that despite all of their efforts in hiring PSWs, some have since resigned and or have been terminated. Additionally, the DOC verified that the PSW staffing plan was being changed effective October 1, 2019, where two full-time PSW positions were being discontinued. Inspector #194 was also informed that the use of agency staff was being discontinued and overtime was going to be minimized when replacing shifts in the home.

During an interview with Inspector #194, the Chief Executive Officer (CEO) indicated there was a reduction of two full-time PSW lines effective October 01, 2019 because of financial commitments.

During an interview with Inspector #194, Unit Payroll Clerk #108 explained the

master schedule rotation for PSW staffing in the home provided for all the full-time PSW lines to be permanently filled. Unit Payroll Clerk #108 indicated that the remaining shifts were filled according to the collective agreement processes.

Review of the PSW master schedule rotations and staffing logs for specified periods, were completed by Inspector #194 and indicated there were PSW shortages on identified home areas.

During an interview with Inspector #194, RPN #132 indicated they worked two of the identified dates. RPN #132 indicated that PSW staff were able to complete the baths, and dressing of residents was a bit delayed explaining that residents were dressed by a specific time. RPN #132 indicated that some of the residents who required two staff assistance with continence care, could not be completed with the staffing levels on the unit.

During an interview with Inspector #194, PSW #130 indicated that they had worked on one of the identified dates. PSW #130 explained that the unit has a number of residents who frequently used the call bell on the their shift, and there were a high number of baths to be completed. PSW #130 indicated that continence care of residents who required two staff assistance with mechanical lifts such as resident #015 and #018 did not occur.

During an interview with Inspector #194, PSW #131 indicated that they had worked on one of the identified shifts. PSW #131 indicated that some residents who required two staff assistance, were not provided continence care, stating that one staff member was pulled to work on another area and the staff were very busy trying to catch up on baths from the previous shifts. PSW #131 indicated that resident #018 was not provided any continence care during the identified shift. PSW #131 indicated that when they came onto shift, residents were stating that it had been pyjama day, indicating that a number of residents had not been dressed during the identified shift.

During an interview with Inspector #194, PSW #129 indicated that they had worked on two of the identified shifts, without a full compliment of staff. PSW #129 indicated that on an identified shift, resident #022 who required two staff assistance with mechanical lift was assisted with continence care once, but was not assisted again, related to insufficient staffing on the unit. PSW #129 indicated that on another identified shift, residents #022, #023, #024, #025, #026 and #027 who required two staff assistance with continence care were provided assistance

once, but were not assisted again, related to insufficient staffing. PSW #129 indicated to Inspector #194 that the RPN on the unit was aware of the situation. PSW #129 indicated that the RPN assisted staff when able, but no other staff were available to assist. Restorative staff were not available as they were pulled to work on an other unit.

During an interview with Inspector #194, PSW #126 indicated they had worked on two of the identified shifts, without the full compliment of PSW staff. PSW #126 indicated that one of the identified shifts, the residents who required two staff assistance back to bed such as resident's #022, #023, #024, #025, #026 and #027, were not provided continence care related to insufficient staffing.

During an interview with Inspector #194, PSW #109 indicated that they had worked one of the identified shifts. The PSW indicated that residents # 015, #017, #018, #019, #020 and #021 requiring two staff assistance with use of mechanical lift did not receive any continence care from staff, after initially coming onto unit, related to insufficient staffing. PSW #109 also indicated that residents #015 and #019 were not dressed related to staffing issues.

The licensee has failed to ensure that the home's PSW staffing plan was implemented to ensure the provision of residents, assessed care needs. The master schedule was posted, with PSW shifts not assigned for specified dates and residents continence care needs were not provided on specified dates. [s. 31. (3)]

Additional Required Actions:

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

(A3)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: 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 failed to ensure that the plan of care as set out in the plan related to continence care was provided to residents #027, #015, #018 and #022 on identified dates.

During a follow-up inspection of the CO#001 related to staffing, clinical health records for resident #027, #015, #018 and #022 was completed by Inspector #194 and concerns related to continence care were identified.

Related to resident #027:

The plan of care for resident #027 indicated a cognitive impairment. Resident #027 was described as requiring two staff assistance for transfers and continence care.

Resident #027 was not interviewed during the inspection related to cognitive impairment.

During an interview with Inspector #194 related to continence care of residents, PSW #126 indicated that they had worked on an identified date. PSW #126 indicated on identified date, that the residents including resident #027, who required two staff assist with mechanical lifts for continence care, were not provided care related to insufficient staffing.

During an interview with Inspector #194, PSW #129 indicated that they had worked on the two identified dates. PSW #129 indicated that on the two identified

dates, residents who required two staff assist, were provided continence care once, and were not assisted again, related to insufficient staffing on the unit. PSW #129 indicated to Inspector #194 that the RPN on the unit was aware of the situation and assisted when able, but no other staff were available to assist. Restorative care staff were not available as they were pulled to work on another unit.

During an interview with Inspector #194, PSW #129 and #126 reviewed Point of Care (POC) flow sheet documentation, indicated that resident #027 would have been provided continence care at two specific times, on the identified date. PSW's indicated that resident #027 was not assisted with continence care at another specified time, on the identified date, related to staffing on the unit. PSW's indicated that the resident would normally be assisted with continence care, three times during the shift.

The licensee failed to ensure that the care set out in the plan related to continence care for resident #027 was provided as specified, on an identified date.

Related to resident #015:

The plan of care indicated that resident #015 required a mechanical lift, with two staff assistance, for all transfers and continence care. Resident #015 was to be provided continence care assistance at identified intervals.

During an interview with Inspector #194, resident #015 was found sitting in their room in their mobility aide, well groomed, with cognitive impairment and unable to inform Inspector #194 how staff were contacted if required. Resident #015 was unable to indicated if they had been provided a bath or if they required assistance with continence care.

During an interview with Inspector #194 related to continence, PSW #109 indicated that resident #015 did not receive any continence care from staff on an identified date after initial care related to insufficient staffing.

During second interview with Inspector #194, PSW #109 reviewed the POC flow sheet documentation indicating that resident #015 would be provided continence care, twice, on the identified shift.

The licensee failed to ensure that the care set out in the plan related to continence for resident #015 was provided as specified on the identified date.

Related to resident #018:

The plan of care described resident #018 as cognitively impaired, totally dependent on staff for all transfers and continence care. Resident #018 was to be provided continence care at identified intervals.

During an interview with Inspector #194 related to continence, PSW #109 identified that resident #018 did not receive any continence care from staff on an identified date, after initial care related to insufficient staffing.

During second interview with Inspector #194, PSW #109 reviewed the POC flow sheet documentation indicating that residents #018 would normally be provided continence care twice during the identified shift. PSW #109 indicated to Inspector #194 that on the identified date, resident #018 was only provided care once during the shift.

The licensee failed to ensure that the care set out in the plan related to continence for resident #018 was provided as specified on the identified date.

Related to resident #022:

The plan of care described resident #022 as cognitively impaired, required two staff assistance with dressing, transferring and continence care. Resident #022 was to be provided assistance by two staff for continence care, every two hours or as needed.

Resident #022 was observed by Inspector #194 frequently manoeuvring in their mobility device on the unit during the inspection. Resident #022 was not able to remember when they were assisted with continence care or by whom.

During an interview with Inspector #194, PSW #126 indicated they had worked on two of the identified shifts. PSW #126 indicated that residents who required two staff assistance with mechanical lift for continence care and be assisted back to bed, were not provided continence care related to insufficient staffing on the unit. PSW #126 indicated that resident #022 was not provided assistance with continence care on an identified date, related to insufficient staffing.

During an interview with Inspector #194, PSW #129 indicated that they had worked on, two of the identified dates. PSW #129 indicated that the unit was working without a full compliment on both shifts. PSW #129 indicated that resident #022 required two staff assistance with mechanical lift and was assisted with continence care once, but was not assisted again during the shift, on both identified dates, related to insufficient staff. PSW #129 indicated to Inspector #194 that the RPN on the unit was aware of the situation. PSW #129 indicated that the RPN assisted staff when able on the weekend, but no other staff were available to assist. Restorative care staff were not available as they were pulled to work on another unit.

During an interview with Inspector #194, PSW #129 confirmed that the documentation recorded on the POC flow sheets for resident #022 on an identified date, indicated continence care occurred a two specific times and not provided again related to staffing on the unit. PSW #129 indicated that resident #022 would be assisted with continence care, three to four times per shift as per the plan of care.

The licensee failed to ensure that the care set out in the plan related to continence care for resident #027, #022, #015 and #018 was provided as specified on the two identified dates, 2019. [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 by ensuring that the care set out in the plan of care, related to continence of residents is provided as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies were developed and implemented to respond to resident #003's responsive behaviours.

A complaint was received by the Director on an identified date, indicating that resident #003 had sustained a fall, while left alone on an identified date.

Review of the current plan of care for resident #003 related to falls was completed by Inspector #194 and indicated, that resident #003 had a cognitive impairment. Resident #003 is described at risk for falls, required two staff assistance for all Activities of Daily Living (ADL's), was dependent on a mobility aide and staff assistance with identified responsive behaviours.

The plan of care for resident #003, related to falls and responsive behaviours were reviewed, with some interventions in place.

Review of the progress notes for resident #003 related to falls and responsive behaviours, for a specific periods, was completed by Inspector #194 and indicated the following:

On a number of specific dates, resident #003 is reported to be exhibiting a responsive behaviour, resulting in falls.

There were a number of additional progress note entries during the reviewed period, where resident #003 is exhibiting the responsive behaviour, placing them at risk for falls.

During a telephone interview with Inspector #194, RN #225 indicated on an identified date resident #003 was found on the floor in the specific area, with lights down low, sitting in front of the mobility device with interventions in place. Resident #003 was assessed with no injury.

During an interview with Inspector #194, PSW #209 indicated on an identified date, resident #003 was transferred to their bedroom, related to responsive behaviour. Resident #003 was in their mobility device, with falls interventions in place when staff left resident #003 in their room. PSW # 117 found resident #003 on the floor.

During an interview with Inspector #194, PSW #117 indicated that on an identified date resident #003 was found on the floor. PSW #117 indicated that previous to the fall resident #003 was sitting in their mobility device, with falls interventions in place. PSW #117 indicated that they could not remember if one specific interventions had been applied. PSW #117 indicated that resident #003 was able to disable one of the falls interventions. PSW #117 indicated that resident #003 did sustain an injury as a result of the fall. PSW #117 stated that two or three days prior to the incident, resident #003 was witnessed exhibiting a new responsive behaviour related to falls and RPN was notified.

During an interview with Inspector #194, RPN #206 indicated being informed that resident #003 was found on floor on an identified date. RPN #206 indicated that they remember checking for falls interventions at the beginning of the shift, but could not remember if the fall interventions was activated at the time of the fall. RPN #206 indicated that resident #003 frequently exhibited the new responsive behaviour, which is why RPN# 206 encouraged a specific fall intervention. RPN #206 indicated that this was not the first time that the responsive behaviour had caused resident #003 to fall.

The plan of care for resident #003 related to falls and responsive behaviour was reviewed and revised after the identified fall, to include further falls interventions.

The licensee has failed to ensure that strategies were developed and implemented to respond to resident #003 responsive behaviours resulting in a

falls, on a number of specific dates. [s. 53. (4) (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 by ensuring that strategies are developed and implemented to respond to resident #003's responsive behaviour, to be implemented voluntarily.

Issued on this 5 th day of January, 2021 (A3)

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DENISE BROWN (626) - (A3)
Inspection No. / No de l'inspection :	2019_603194_0022 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	010330-19, 013264-19, 013911-19, 015327-19, 017366-19, 018913-19, 018962-19 (A3)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 05, 2021(A3)
Licensee / Titulaire de permis :	Trent Valley Lodge Limited 195 Bay Street, Trenton, ON, K8V-1H9
LTC Home / Foyer de SLD :	Trent Valley Lodge 195 Bay Street, Trenton, ON, K8V-1H9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kelly Slawter

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 Trent Valley Lodge Limited, 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

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_603194_0009, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 31(3) of O. Reg. 79/10.

The licensee shall prepare, submit and implement a plan to ensure compliance with s. 31(3) of O. Reg 79/10

The plan must include, but is not limited to the following:

1. Ensure the staffing plan provides for a staffing mix that is consistent with residents assessed care and safety needs.

2. Develop a plan to ensure vacant shifts are filled and include a back up plan when available shifts are not filled.

3. Develop a recruitment and retention plan to facilitate the filling of vacant positions.

Please submit the written plan, quoting the Inspection # 2019_603194_0022 and Inspector Chantal Lafreniere by email to: CentralEast SAO.MOH@ontario.ca by January 10, 2020

Grounds / Motifs :

(A1)
1. The licensee failed to provide a PSW staffing mix that was consistent with the resident's assessed continence care needs.

A compliance Order (CO) #001 was issued to the licensee on May 14, 2019, under O. Reg 79/10, s. 31(3) within report # 2019_603194_0009 with a compliance date of July 17, 2019. On July 15, 2019 the licensee requested an extension of the compliance due date, which was granted and extended to September 17, 2019. On September 09, 2019 the licensee requested a further extension of the compliance due date, which was not granted. The licensee had been previously issued CO #002, under the same legislation on January 16, 2019 with report # 2018_603194_0019 with a compliance date of March 4, 2019.

On May 14, 2019 the licensee was ordered to:
-provide a staffing mix that is consistent with the residents assessed care and safety needs.

-ensure that the residents are bathed, at a minimum twice weekly by the method of their choice.
-ensure that residents are provided continence care according to their assessed care needs, specifically residents who required two staff assistance for continence care.

During an interview with Inspector #194, the Administrator verified that the home's census was 121 beds. The Administrator provided the inspector with the current PSW staffing plans and explained that due to budgetary commitments a reduction in PSW staffing would be in effect October 01, 2019.

Inspector #194 verified the PSW staffing in the home by reviewing the PSW schedules for a specified period. The PSW schedules indicated that there were a total of 48 (8 hour shifts) and 55.5 hours that the home had not been able to fill during the reviewed period.

Review of the resident census and PSW staffing plan in the home, after October 1, 2019, indicated no change to the resident census and the staffing plan indicated that two float positions were removed.

Inspector #194 verified the PSW staffing in the home by reviewing the PSW schedules for an other specified period. The PSW schedules indicated that there were a total of 29 (8 hour shifts) and 22 PSW hours that the home had not been able to fill during the reviewed period.

An interview with the DOC indicated there were a specified number full-time, permanent part-time and casual PSWs currently employed at the home. The DOC indicated there is a high number of leave of absences (LOA) in the home contributing schedule vacancies. The DOC further indicated that hiring for vacant LOA positions has been difficult, as no permanent positions can be offered. The DOC confirmed that despite all of their efforts in hiring PSWs, some have since resigned and or have been terminated. Additionally, the DOC verified that the PSW staffing plan was being changed effective October 1, 2019, where two full-time PSW positions were being discontinued. Inspector #194 was also informed that the use of agency staff was being discontinued and overtime was going to be minimized when replacing shifts in the home.

During an interview with Inspector #194, the Chief Executive Officer (CEO) indicated

there was a reduction of two full-time PSW lines effective October 01, 2019 because of financial commitments.

During an interview with Inspector #194, Unit Payroll Clerk #108 explained the master schedule rotation for PSW staffing in the home provided for all the full-time PSW lines to be permanently filled. Unit Payroll Clerk #108 indicated that the remaining shifts were filled according to the collective agreement processes.

Review of the PSW master schedule rotations and staffing logs for specified periods, were completed by Inspector #194 and indicated there were PSW shortages on identified home areas.

During an interview with Inspector #194, RPN #132 indicated they worked two of the identified dates. RPN #132 indicated that PSW staff were able to complete the baths, and dressing of residents was a bit delayed explaining that residents were dressed by a specific time. RPN #132 indicated that some of the residents who required two staff assistance with continence care, could not be completed with the staffing levels on the unit.

During an interview with Inspector #194, PSW #130 indicated that they had worked on one of the identified dates. PSW #130 explained that the unit has a number of residents who frequently used the call bell on the their shift, and there were a high number of baths to be completed. PSW #130 indicated that continence care of residents who required two staff assistance with mechanical lifts such as resident #015 and #018 did not occur.

During an interview with Inspector #194, PSW #131 indicated that they had worked on one of the identified shifts. PSW #131 indicated that some residents who required two staff assistance, were not provided continence care, stating that one staff member was pulled to work on another area and the staff were very busy trying to catch up on baths from the previous shifts. PSW #131 indicated that resident #018 was not provided any continence care during the identified shift. PSW #131 indicated that when they came onto shift, residents were stating that it had been pyjama day, indicating that a number of residents had not been dressed during the identified shift.

During an interview with Inspector #194, PSW #129 indicated that they had worked on two of the identified shifts, without a full compliment of staff. PSW #129 indicated

that on an identified shift, resident #022 who required two staff assistance with mechanical lift was assisted with continence care once, but was not assisted again, related to insufficient staffing on the unit. PSW #129 indicated that on another identified shift, residents #022, #023, #024, #025, #026 and #027 who required two staff assistance with continence care were provided assistance once, but were not assisted again, related to insufficient staffing. PSW #129 indicated to Inspector #194 that the RPN on the unit was aware of the situation. PSW #129 indicated that the RPN assisted staff when able, but no other staff were available to assist. Restorative staff were not available as they were pulled to work on an other unit.

During an interview with Inspector #194, PSW #126 indicated they had worked on two of the identified shifts, without the full compliment of PSW staff. PSW #126 indicated that one of the identified shifts, the residents who required two staff assistance back to bed such as resident's #022, #023, #024, #025, #026 and #027, were not provided continence care related to insufficient staffing.

During an interview with Inspector #194, PSW #109 indicated that they had worked one of the identified shifts. The PSW indicated that residents # 015, #017, #018, #019, #020 and #021 requiring two staff assistance with use of mechanical lift did not receive any continence care from staff, after initially coming onto unit, related to insufficient staffing. PSW #109 also indicated that residents #015 and #019 were not dressed related to staffing issues.

The licensee has failed to ensure that the home's PSW staffing plan was implemented to ensure the provision of residents, assessed care needs. The master schedule was posted, with PSW shifts not assigned for specified dates and residents continence care needs were not provided on specified dates. [s. 31. (3)]

The decision to issue a Director's Referral and Compliance Order was based on the following; The severity of this issue was determined to be a level 2 with minimal risk to resident. The scope of the issue was a level 3 determined as widespread. The compliance history of the home was level 4 determined by the re-issuing of CO to the same subsection under 31(3) and three or more COs indicated in the following reports;
CO # 2019_603104_0009 and CO #2018_603194_0019.

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

(194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 28, 2021(A3)

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

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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

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

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
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.

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

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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 5 th day of January, 2021 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by DENISE BROWN (626) - (A3)

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

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Service Area Office / Bureau régional de services : Central East Service Area Office