Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 23, 2021	2021_885601_0015	006409-21, 007517-21, 007883-21, 007890-21, 008190-21, 010958-21	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

KARYN WOOD (601), SARAH GILLIS (623)

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): On-site June 14, 15, 16, 17, 18, 21, 22, 23, July 6, 7, 8, 9, 19, 20, 21, 22, 23, 26, and 27, 2021. Off-site June 24, 25, July 5, 12, 13, 14, 15, 16, 2021.

The following intakes were completed in this Complaint Inspection:

Log #006409-21, Log #007517-21, and Log #010958-21 related to staffing shortages, care concerns with allegations of neglect.

Log #007883-21 and Log #007890-21 were the same issue related staffing shortages, care concerns with allegations of neglect.

Log #008190-21 related to staffing shortages, care concerns and pain management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Care Coordinator (CCC), Registered Practical Nurse/Nursing Manager (RPN/NM), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Acting Laundry/Housekeeping/Nutritional Supervisor, Housekeeping/Dietary Aide, Personal Support Workers (PSW), Support Service Worker (SSW), Dietary Aide (DA), Life Enrichment Coordinator (LEC), Activity Aide (AA), Administrative Assistant (Admin A), Hastings Prince Edward Public Health Nurse (PHN), residents and resident's Substitute Decision Makers (SDM).

Please Note: Within concurrent CIS inspection #2021_885601_0014, a finding of non-compliance under s.19 and s. 24. (1) of the LTCHA was noted and will be issued within this Complaint Inspection #2021_885601_0015 report.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **12 WN(s)**
- **2 VPC(s)**
- **12 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to the failure to maintain infection prevention and control measures specified in Directive #3 regarding the proper use of eye protection, medical mask, and maintaining two meters distance from others while not wearing a mask.

Staff were observed without eye protection, wearing eye protection on their forehead, and with eye protection that was not government approved for Personal Protective Equipment (PPE) when they were within two meters of a resident. Physical distancing was not being maintained and several staff were observed to be within two meters of others with no medical procedure mask or with the mask not covering their mouth and/or nose.

The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to long-term care homes and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in long-term care homes. As per Directive #3 from June 9 to July 16, 2021, all staff of long-term care homes were required to wear eye protection when they were within two meters of a resident. Staff are always to comply with universal masking, even when they are not delivering direct patient care, including in administrative areas. During their breaks, to prevent staff to staff transmission of COVID-19, staff must always remain two meters away from others and be physically distanced before removing their medical mask for eating and drinking. Masks must not be removed when staff are in contact with residents and/or in designated resident areas. The mask must be covering their nose and mouth. The Hastings Prince Edward Public Health Nurse confirmed the staff should be wearing their mask covering their nose and mouth, as per Directive #3.

The lack of adherence to Directive #3 related to the use of eye protection, universal mask use and physical distancing presented an actual risk of exposing the residents to COVID-19.

Sources: Directive #3 (version effective date June 9, 2021 and July 16, 2021), observations throughout the home by Inspector #601 and Inspector #623 and interview with Hastings Prince Edward Public Health Nurse. [s. 5.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 resident #014's plan of care included clear directions to staff related to when the resident's wound care treatment should be provided.

PSWs reported they were concerned the resident had not received wound care to a new skin impairment due to staffing shortages. PSWs interviews and record review of the resident's Point of Care (POC) flow sheet indicated the resident had impaired skin integrity and the registered staff were made aware. On the following day, an RPN documented staff had reported the resident had a specified wound and the treatment

was added to the wound care flow sheet. Record review of the wound care flow sheet identified there was no direction regarding the wound care treatment required for the resident's most recent wound nor when the specified skin impairment was first discovered.

The CCC indicated they were not aware of the specified wound and they had reviewed and updated the resident's wound care flow sheet prior to the wound being present. The CCC indicated the resident did have impaired skin integrity and the resident's wound care treatment was scheduled for regular, weekly intervals. They further indicated there was a wound care binder that included the resident's individual treatment plan with the location of the wound and the registered staff would complete the wound care on the scheduled day. Review of the resident's treatment plan for wound care indicated the resident had four areas of impaired skin integrity. The CCC indicated they assessed the resident following an interview with the Inspector and reported the resident had a new wound. The CCC acknowledge the wound care flow sheet regarding the resident's wound care treatment was not clear and did not include the treatment of the resident's most recent wound.

There was actual risk the resident's most recent wound could have worsened when there was not clear direction regarding the treatment plan and that a clinically appropriate skin assessment was not scheduled to be completed to evaluate the effectiveness of the treatment.

Sources: Review of a resident progress notes, care plan, head to toe skin bath assessments, Wound Care Required, POC flow sheet, interviews with PSWs, and the CCC. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff collaborated with the physician and each other when resident #016 was experiencing impaired skin integrity so that their assessments were integrated, consistent with and complemented each other.

Non-compliance was identified with s. 6. (4) (a) related to a resident and the sample size was expanded to include resident #016.

The resident's progress notes identified the resident had impaired skin integrity for several days prior to the physician prescribing a medicated cream for a specified number of days to treat the resident's impaired skin integrity. The documentation indicated the resident had impaired skin integrity after the completion of the medicated cream and prior

to the inspection. During the inspection, the resident reported they had skin discomfort and that staff had been applying a medicated cream. A PSW indicated the resident had impaired skin integrity and they had reported to registered staff that they had applied the medicated cream. Registered staff interviewed acknowledged the resident's specified area was prone to impaired skin integrity but they were not aware the resident was reporting skin discomfort nor that PSWs were applying the medicated cream at the request of the resident.

There was no evidence that staff had collaborated with the physician regarding the resident's impaired skin integrity until several days after the skin impairment was first documented and the physician prescribed the medicated cream to treat the resident's skin infection. The resident was at risk for discomfort and further impaired skin integrity when the registered staff and physician were not aware that the resident was experiencing impaired skin integrity at the time of this inspection and that the PSWs were applying a medicated cream that was prescribed to be applied when required.

Sources: Resident's care plan, progress notes, care plan, Head to Toe Skin Bath Assessments, Medication Administration Record, physician orders, interviews with PSWs, RPNs, RN, and the CCC. [s. 6. (4) (a)]

3. The licensee has failed to ensure that staff collaborated with the physician and each other when resident #001 was experiencing pain, and symptoms of an infection so that their assessments were integrated, consistent with and complemented each other.

A complaint was submitted to the Ministry of Long-Term Care with allegations that the resident's pain and infections were not be managed.

The resident's SDM reported they had concerns that registered staff did not collaborate with the physician regarding the resident experiencing pain, symptoms of infection and their request for a medical test.

The resident's SDM requested a lab test be completed as the resident had a change in health condition. RPN #114 documented the resident had a bit of pain, and that the PSW and the resident's SDM reported the resident had complained of pain in the past and a note was left in the physician's book requesting a medical test. A few days after the resident's SDM's requested the lab test and medical test, RPN #124 documented they had consulted with the charge nurse regarding the resident's pain and the SDM's request for a medical test. RPN #124 documented they were not aware of the resident

experiencing specified pain but the PSWs reported the resident often reported pain. PSW #121 indicated they had reported to the registered staff that the resident was experiencing pain and the resident's pain was not managed. RPN #114 indicated the resident received pain medication regularly that was not always effective. RPN #114, Clinical Care Coordinator (CCC), and the nurse manager (RPN/NM) indicated they were not aware of the physician being informed of the resident experiencing the pain until the medical test was ordered by the physician which was several weeks after the resident's SDM's initial request.

The resident's SDM suspected the resident had an infection and requested a lab test be completed on two specified dates. The physician ordered the lab test on a few different dates and the specimen was collected and sent to the lab a week after the physician ordered the lab test. The specimen was sent to the lab several weeks after the resident's SDM's requested and the results of the lab test were positive for an infection.

There was no evidence that staff collaborated with the physician when the resident was experiencing pain and symptoms of infection for several weeks. The resident was at risk for discomfort and complications of infection when registered staff did not collaborate with the resident's physician regarding the resident experiencing pain and symptoms of infection.

Sources: Review of resident progress notes, plan of care, Signs and Symptoms of Infection, policy, Life lab reports printed, physician orders, interviews with PSW, RPN, RPN/NM, CCC, and the resident's SDM. [s. 6. (4) (a)]

4. The licensee has failed to ensure that staff collaborated with the physician, Dietitian, Physiotherapist, and each other when resident #018 was having difficulties with eating and decreased nutritional intake so that their assessments were integrated, consistent with and complemented each other.

A complaint was brought forward to the Ministry of Long-Term Care that the resident was not being offered sufficient fluids.

Inspector #623 observed the resident during their meal and identified the resident was not positioned properly during their meal. Review of the care plan identified the resident was to be positioned in a full sitting position during meals.

The resident was having difficulties eating and taking their medication, was refusing to

eat and the resident's Substitute Decision Maker (SDM) reported the resident had decreased nutritional intake. The following week, the resident's SDM requested the resident be assessed by a specialist and that the physician be notified that the resident had decreased nutritional intake and difficulties with eating. The RN documented their assessment of the resident and that a note would be left for the physician to assess during their next visit. The following week, the RPN documented their assessment of the resident. The RPN contacted the resident's SDM and discovered the resident's SDM had previously requested the physician assess the resident for the issue being identified by the RPN. The following week, the resident started on medication to treat an infection. The RPN documented the resident's SDM requested for a medical test and that a referral to a specialist. The resident's SDM was informed the medical test for the resident had been ordered by the physician two days earlier.The resident's SDM indicated they had not been made aware of the new orders and requested an explanation from the charge nurse. The following week, RPN/NM documented in the resident's progress notes that the resident's SDM was notified the specialist referral would be completed within the week as the physician wanted the resident's infection to clear up and the medical test to be completed prior to referring to the specialist.

The Dietitian indicated to Inspector #623 that they were not aware of the resident's difficulties with eating, decreased nutritional intake or that the resident's SDM had requested the resident be assessed by a specialist. CCC #102 confirmed that a referral had not been made to the Dietitian regarding the resident's decreased nutritional intake, difficulties with eating and that a referral had not been made to the Physiotherapist to assess the residents positioning during meal service.

There was no evidence that staff collaborated with the physician, Dietitian, or Physiotherapist when the resident's SDM requested the resident be assessed three times nor that the staff communicated the physicians findings to the resident's SDM when the physician had prescribed medication to treat the resident's infection.

The resident was at risk for a negative outcome when they were not properly positioned during meals and collaboration with the Physiotherapist would allow for a proper seating assessment. The resident's difficulties with eating were first noted by staff and the resident's SDM several weeks before the physician was made aware and this placed the resident at risk for decreased nutritional intake and discomfort as they were not able to communicate the reason they were having difficulties with eating.

Sources: Resident's progress notes, care plan, physician orders, Medication

Administration Record, and interviews with RPN/NM, CCC, and resident's SDM. [s. 6. (4) (a)]

5. The licensee has failed to ensure that the care set out in the plan of care for resident #001, #012, #013, #014, #016, #017, #018, #021, #026, and #028 related to continence care was provided to the residents, as specified in the plan.

Resident #001's plan of care related to continence care directed for the resident to receive total assistance from two staff for continence care. PSWs acknowledged continence care was delayed on the resident's specified floor when they were working with two PSWs instead of three PSWs on the days and evening shifts and they did not always have time to provide the resident's continence care as directed in the care plan. Resident #001 was at risk for altered skin integrity and urinary tract infections when continence care was not always provided to the resident, as specified in the care plan due to the resident being incontinent.

Resident #012's care plan related to continence care directed for the resident to receive total assistance from two staff for continence care. The Ministry of Long-Term Care received two complaints related to staffing shortages, care concerns with allegations of neglect due to care not being provided as directed in the resident's plan of care. The RPN reported the resident was crying when they entered the resident's room and discovered the resident had not received care from 0600 hour to 1200 hour on a specified date. Staff failed to provide the assistance required to resident #012 as continence care was not provided for six hours on a specified date and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #013's care plan related to continence care directed for the resident to receive extensive assistance from two staff for continence care. PSW #108 reported the resident had not received continence care as specified in their plan of care. The PSW reported that they were working with two modified staff who were unable to assist with resident care and transfers. They indicated they did not have time to provide the resident's care more than twice on the evening shift due to the workload and responding to several call bells. According to the PSW, the resident's incontinent product was saturated with urine and the resident was a high risk for urinary tract infections. PSW #111 reported a PSW working on the resident's specified floor had been relocated to the another location after breakfast due to staffing shortages. As a result of the staffing changes, the PSW reported the resident received continence care prior to 0700 hour and that they did not have time

to provide the resident's care after breakfast or before lunch. Staff failed to provide the assistance required to resident #013 as continence care was not provided for five hours on two specified dates and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #014's care plan related to continence care directed for the resident to receive total assistance from two staff for continence care. PSW #108 reported the resident had not received continence care as specified in their plan of care. The PSW reported that they were working with modified staff who were unable to assist with resident care and transfers. They indicated they did not have time to provide the resident's care due to the workload and responding to several call bells. According to the PSW, the resident's incontinent product was saturated with urine and the resident had been incontinent of stool. PSW #111 reported a PSW working on the resident's specified floor had been relocated to another location after breakfast on a specified date due to staffing shortages. As a result of the staffing changes, the PSW reported the resident received continence care prior to 0700 hour and that they did not have time to provide the resident's care after breakfast or before lunch. Staff failed to provide the assistance required to resident #014 as continence care was not provided for seven hours on a specified date, and for five hours on the other specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #016's care plan related to continence care directed for the resident to receive total assistance from two staff for continence care. Resident #016 indicated they were able to request assistance to use the toilet and there were times when PSWs told them they would have to wait due to a second staff not being available to assist. The resident further indicated as a result they would be incontinent. PSWs acknowledged continence care could be delayed on the resident's specified floor when they were working with less than four PSWs on the days and evening shifts. PSWs further indicated that the resident could request assistance with toileting and there were times when the resident was incontinent due to staff not being available to assist the resident with toileting upon request. Resident #016 was at risk for altered skin integrity and urinary tract infections when toileting assistance was not always provided to the resident, as specified in the care plan due the resident being immobile and incontinent.

Resident #017's care plan related to continence care directed for the resident to receive total assistance from two staff. A PSW reported a PSW working on the resident's specified floor had been relocated to another location after breakfast on a specified date due to staffing shortages. As a result of the staffing changes, the PSW reported the

resident received continence care prior to 0700 hour and that they did not have time to provide the resident's care after breakfast or before lunch. Staff failed to provide the assistance required to resident #017 as continence care was not provided for five hours on a specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #018's care plan related to continence care directed for the resident to receive total assistance from two staff. The Ministry of Long-Term Care received a complaint related to staffing shortages and that the resident had not received continence care for ten hours. On the specified date, the PSW working on the day shift completed POC documentation at 1037 hour and the documentation indicated the resident had been toileted once on the day shift and the PSW working on the evening shift completed the documentation at 1946 hour and the documentation indicated the resident had been toileted three times on the evening shift. The DOC indicated they were aware of the allegations from the resident's SDM and the charge RN had interviewed the PSW working the evening shift on the specified date, and it was reported the resident had received continence care at 1500 hour. The resident's SDM reported they had evidence the resident's continence care was not provided for ten hours, record review and staff interviews indicated the resident had not received continence care for four and a half hours. PSWs interviewed indicated there were times when two PSWs were working on the resident's floor and they were not able to ensure the resident received continence care according to their assessed needs. Staff failed to provide the assistance required to resident #018 as continence care was provided once on the day shift on a specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #021's care plan related to continence care directed for the resident to receive limited assistance from one staff. PSWs reported that resident #021 had not received morning care due to staffing shortages on a specified date. The PSWs acknowledged there was no communication from the night shift regarding when the resident had last received continence care. The Resident Assessment Instrument (RAI) Coordinator confirmed at 0930 hour, that resident care and meal service was behind on the resident's specified floor due to staffing shortages. Staff failed to provide the assistance required to resident #021 as continence care was not provided for four hours on the specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #026's care plan related to continence care directed for the resident to receive

total assistance from two staff. PSWs reported that resident #026 had not received morning care due to staffing shortages on a specified date. The PSWs acknowledged there was no communication from the night shift regarding when the resident had last received continence care and they had started their shift at 0600 hour. The RAI Coordinator confirmed at 0930 hour, that resident care and meal service was behind on the resident's specified floor due to staffing shortages. Staff failed to provide the assistance required to resident #026 as continence care was not provided for four hours on the specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #028's care plan related to continence care directed for the resident to receive total assistance from two staff. Resident #028 reported there were times when they would ring their call bell and staff did not immediately respond. Resident #028 indicated their bottom gets sore and on a specified date they had not received continence care or returned to bed after breakfast when they requested. A PSW confirmed the resident had not received continence care after breakfast and that there were staffing shortages on the specified date. A PSW reported there was a day when they had worked with three PSWs and one of the three PSWs was not familiar with the residents on the resident's floor. They further indicated resident care was behind on this day due to staffing shortages and resident #028 was angry at the staff because they didn't have time to assist the resident with continence care and assist the resident to bed for a rest. The PSW further indicated the resident would have received continence care at around 0730 hour on this day and the resident did not receive continence care after breakfast or before lunch. They reported the resident's continence care was provided in the afternoon and the resident's brief and clothing was saturated with urine. Staff failed to provide the assistance required to resident #028 when continence care was not always provided to the resident upon request, before and after meals and when continence care was not provided after breakfast on the specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Record review of resident #001, #012, #013, #014, #016, #017, #018, #021, #026, and #028's Point of Care (POC) documentation related to continence care and toileting did not support that the residents were consistently provided continence care as specified in their individual plan of care. PSWs acknowledged they did not always have time to provide continence care before and after meals when working with staffing shortages. PSWs interviewed indicated that on the day and evening shift four PSWs were required to work on the third floor and three PSWs were required to work on the first floor to ensure that all the residents received care according to their assessed needs. PSWs

further indicated that modified staff were not always replaced, and this affected resident care as the modified staffs' ability to assist with resident care was limited and two PSWs could be responsible to provide toileting and continence care for all of the residents on the third floor. PSWs indicated they did their best to toilet the resident according to their plan of care, and when the resident requested to use the toilet but there were times when the resident's continence care would be delayed due to staffing shortages. The DOC confirmed there were staffing shortages and times on the day and evening shifts when two PSWs were assigned to work on the first floor and when three PSWs were assigned to work on the third floor. The DOC indicated they were not aware of any residents not receiving assistance with toileting or continence care and that residents should receive care as specified in the plan of care.

Sources: Resident #001, #012, #013, #014, #016, #017, #018, #021, #026, and #028's care plan, progress notes, quarterly continence assessment, POC documentation, interviews with PSWs, RPNs, and RNs, CCC, the DOC, and residents. [s. 6. (7)]

Additional Required Actions:

CO # - 002, 011 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents #004, #005, #006, #007, #008 and #009 from physical, and verbal abuse.

A Critical Incident Report (CIR) related to allegations of staff to resident physical and verbal abuse was submitted to the Ministry of Long-term Care.

Under O.Reg. 79/10 s.2. (1) For the purposes of the definition of “abuse” in subsection 2 (1) of the Act,

“verbal abuse” means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident,

“physical abuse” means, subject to subsection the use of physical force by anyone other than a resident that causes physical injury or pain.

The CIR was submitted to the Director for allegations of abuse by PSW #125 and PSW #126 towards resident’s #004, #005, #006, #007, #008 and #009.

Review of the licensee’s internal investigation identified the following incidents had been ongoing over a period of approximately three months:

Resident #004 – Staff reported to observe PSW #126 be physically and verbally aggressive when providing care, yell at the resident “come on, move your arm” and flip them when providing care. PSW #152 reported that PSW #126 would refuse to lay resident #004 down and they were only ever toileted once in the shift.

Resident #005 – PSW #127, #128, #150 and #152 each reported that when providing care to resident #005, PSW #125 and #126 would pull their mask down, point to their cheek and say to the resident “hit me right here, then I can go home”. PSW #128 reported that PSW #126 indicated they would say this to resident #005 to “control their behaviour”. PSW’s indicated that once the resident was up in the morning which was usually around 0600 hour, care was not provided again until bedtime.

Resident #006 – PSW #128 and #150 each reported that PSW #126 would forcefully push resident #006 down into the bathtub while the resident was screaming “no, no, no”. PSW #126 would say “you have to have a bath”.

Resident #007 – During an interview with resident #007, the resident reported that two to three PSW’s were always very short with the resident when providing morning care and expressed concerns that other residents were also being treated the same way. The resident declined to name the PSW’s. PSW’s #128 and #150 reported that PSW’s #125 and #126 would speak in an aggressive manner to resident #007. They would tell the

resident they didn't have time to complete a task after the resident's bath, would grab the resident roughly causing the resident to say "ouch". PSW #150 also reported that PSW #126 would refuse to provide care to resident #007 stating that the resident had a behaviour and "there were more important resident's that needed care". PSW #127 reported that when resident #007 spilled a beverage on their pants, PSW #125 refused to assist the resident to be changed stating "Are you kidding me, I don't have time for this". The housekeeper assisted PSW #127 to change resident #007.

Resident #008 - PSW #152 reported that when assisting PSW #126 to provide care to resident #008, the resident was very vocal. PSW #126 told resident #008 to "shut up and stop talking". Activation Aide (AA) #133 reported to have observed PSW #126 grab resident #008's hand out of the air and force it down. The PSW would speak to the resident in a harsh tone.

Resident #009 – AA #151 reported that resident #009 was in the dining room and requested to go to the bathroom, PSW #125 told the resident to "go in their brief", they didn't have time to take them to the bathroom.

The investigation interviews indicated that PSW #125 and #126 each confirmed the allegations against them. The PSW's indicated they were frustrated with working short staffed or being partnered with staff who were unable to perform all of the required duties.

During separate interviews Life Enrichment Coordinator (LEC) #132 and Administrative Assistant (AdminA) #145 indicated that they conducted the initial incident investigation together. During the interview, resident #007 was reluctant to identify the staff by name for fear of retaliation. The resident did confirm that there were two to three staff who were impatient and rushed when care was provided and didn't always complete all tasks. The LEC and AdminA both confirmed that during the investigation interviews, it was revealed by staff who were interviewed, the abuse had been ongoing for approximately three months, and the frontline staff who were aware of it did not report the incidents. The frontline staff indicated they were fearful of retaliation from PSW #125 and #126 if they had reported the incidents. The registered staff seemed unaware that the incidents had occurred.

During an interview the Director of Care (DOC) indicated that any alleged, suspected or witnessed abuse of a resident is to be immediately reported. The DOC indicated that in 2020 all staff had not received any training related to the homes abuse policy which

includes the duty to report, until after this incident investigation was completed in December 2020. The education was provided to staff during a staff meeting and as a read and sign of the policy which was attached to their pay stubs. The DOC was unaware of when any education had been provided prior to that date. The DOC indicated the outcome of the licensee's investigation confirmed that actual abuse towards resident's #004, #005, #006, #007, #008 and #009 by PSW #125 and #126 did occur.

Residents #004, #005, #006, #007, #008 and #009 were at risk of ongoing actual abuse by PSW #125 and PSW #126 when frontline staff were aware of the abuse and did not report it for approximately three months. The residents were repeatedly subjected to physical and verbal abuse, refusal of care to be provided, instructed to "go in their brief" when asked to use the bathroom, exposed to staff who pulled down their mask within close proximity to the resident, and told to punch staff so that the staff could go home.

Sources: Critical Incident Report, internal investigation documents, interviews with staff. (623) [s. 19. (1)]

2. The licensee has failed to protect residents #012, #013, #014, #017, #018, #021, and #026 from neglect when continence care was not provided to the resident, as specified in the plan.

For the purposes of the Act and this Regulation:

"neglect" means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Multiple staff and family members reported they were concerned the residents were not receiving proper care due to the limited amount of time and staff to provide the residents' care. Staff interviewed indicated they were exhausted from the extensive workload and from working overtime due to the staffing shortages.

Three residents indicated there were times when staff were not able to assist them with toileting assistance when requested, as the staff reported there were staffing shortages and they didn't have the time. Two of the resident's reported they were able to request staff assistance for toileting and there were times when they would be incontinent as the staff reported they didn't have time to provide the assistance. A resident further indicated agency staff were not always aware of their care needs, staff rush during care and they

felt bad because they needed extra time with care, but they were not able to assist with their care due to their physical limitations.

The Ministry of Long-Term Care received two complaints related to staffing shortages, care concerns with allegations of neglect due to care not being provided as directed in the resident's plan of care. Resident #012's care plan related to continence care directed for the resident to receive total assistance from two staff. The RPN reported the resident was crying when they entered the room and discovered the resident had not received care from 0600 hour to 1200 hour. Staff failed to provide the assistance required to resident #012 as continence care was not provided for six hours on a specified date and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #013's care plan related to continence care directed for the resident to receive extensive assistance from two staff. PSW #108 reported resident #013 received continence care at 1400 and 1900 hour, on a specified date due to staffing shortages. According to the PSW, the resident's incontinent product was saturated with urine and the resident was a high risk for urinary tract infections. PSW #111 reported the resident received continence care prior to 0700 hour and that they did not have time to provide the resident's care after breakfast or before lunch, on a specified date due to staffing shortages. The DOC confirmed there were staffing shortages on the two specified shifts. Staff failed to provide the assistance required to resident #013 as continence care was not provided for five hours on two specified dates and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #014's care plan related to continence care directed for the resident to receive total assistance from two staff. PSW #108 reported resident #014 received care once on their shift at 2100 hour, on a specified date. According to the PSW, the resident's incontinent product was saturated with urine and the resident had been incontinent of stool. PSW #111 reported the resident received continence care prior to 0700 hour and that they did not have time to provide the resident's care after breakfast or before lunch at 1215 hour due to staffing shortages. The DOC confirmed there were staffing shortages on the two specified shifts. Staff failed to provide the assistance required to resident #014 as continence care was not provided for seven hours on a specified date, and for five hours on a specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #017's care plan related to continence care directed for the resident to receive

total assistance from two staff. PSW #111 reported the resident received continence care prior to 0700 hour and that they did not have time to provide the resident's care after breakfast or before lunch on a specified date due to staffing shortages. The DOC confirmed there were staffing shortages on the specified shift and that they were not aware of any residents not receiving continence care. Staff failed to provide the assistance required to resident #017 as continence care was not provided for five hours on a specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

The Ministry of Long-Term Care received a complaint related to staffing shortages and that the resident had not received continence care for ten hours. Resident #018's care plan related to continence care directed for the resident to receive total assistance from two staff. On the specified date, the PSW working on the day shift completed POC documentation at 1037 hour and the documentation indicated the resident had been toileted once on the day shift and the PSW working on the evening shift completed the documentation at 1946 hour and the documentation indicated the resident had been toileted three times on the evening shift. The DOC indicated they were aware of the allegations from the resident's SDM and the charge RN had interviewed the PSW working the evening shift on the specified date, and it was reported the resident had received continence care at 1500 hour. The resident's SDM reported they had evidence that the resident's continence care was not provided for ten hours, record review and staff interviews indicated the resident had not received continence care for four and a half hours. Staff failed to provide the assistance required to resident #018 as continence care was provided once on the day shift on the specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #021's care plan related to continence care directed for the resident to receive limited assistance from one staff. PSWs reported that resident #021 had not received morning care due to staffing shortages on a specified shift. The PSWs acknowledged there was no communication from the night shift regarding when the resident had last received continence care. The RAI Coordinator confirmed at 0930 hour, that resident care and meal service was behind on the resident's specified floor due to staffing shortages. Staff failed to provide the assistance required to resident #021 as continence care was not provided for four hours on the specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #026's care plan related to continence care directed for the resident to receive total assistance from two staff. PSWs reported that resident #026 had not received morning care due to staffing shortages on a specified shift. The PSWs acknowledged there was no communication from the night shift regarding when the resident had last received continence care and they had started their shift at 0600 hour. The RAI Coordinator confirmed at 0930 hour, that resident care and meal service was behind on the resident's specified floor due to staffing shortages. Staff failed to provide the assistance required to resident #026 as continence care was not provided for four hours on the specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

The DOC indicated attempts for staff recruitment was ongoing and at the time of the interview there were several PSW part-time positions that remained vacant. There was also one RN part-time night line and one RPN part-time night line vacant. According to the DOC, several agency staff have been working in the home and efforts have been made to provide continuity of resident care.

The licensee has not been able to recruit and retain staff according to the home's staffing plan and there was actual risk of harm that several residents' assessed care needs according to the staffing plan were not met when the home did not have the full complement of staff working. Staffing shortages in the home puts the residents at risk due to the staff reporting they don't have enough time to provide proper care to the residents. Staff are rushed and they can be short tempered while providing care or when asked to assist with care. The staff report they do their best to provide care to the residents, but they need to take short cuts putting the residents and themselves at risk for injury. Staff, residents, and their families reported they are worried about the safety of the residents due to staffing shortages, they are frustrated, and don't feel supported.

Further, the shortage of staff and its impact on residents not receiving care according to the plan of care, including continence care or delayed care demonstrates that the licensee did not ensure that residents assessed needs were met and that the residents were protected from neglect.

Sources: Review of several residents clinical health records, Master Schedule, Daily Staffing Sheets, Staffing plan for 2020, Evaluation of Staffing Plan 2020/2021, interviews with PSWs, RCAs, RPNs, RN's, AA's, HSKs, DAs, RAI Coordinator, CCC, Admin A, LEC, and DOC, residents and resident SDM's. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff, that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A Critical Incident Report (CIR) was submitted to the Director for an allegation of abuse by PSW #125 and PSW #126 towards residents #004, #005, #006, #007, #008 and #009. The CIR indicated that PSW #127 reported the allegations to the Manager of Life Enrichment (LEC) #132.

During an interview LEC #132 indicated that PSW #127 had reported to the Director of Care (DOC) that they were feeling bullied by PSW #125 and PSW #126. The LEC and Administrative Assistant (AdminA) #145 had been directed to conduct a preliminary investigation interview with PSW #127 to gather details of their allegation. During this

investigation interview, the PSW reported the allegation of abuse towards multiple residents. This was the first time that PSW #127 had reported these allegations. The LEC indicated that they reported the information to the DOC and were instructed to interview all of the staff involved and the residents if able. Once all of the interviews were completed, the DOC took over the investigation. The LEC indicated that the DOC would have submitted the report to the Director.

During an interview the DOC indicated they submitted the CIR, once the allegations were confirmed and did not immediately report the allegation. The DOC indicated that they interviewed staff first to ensure that there was truth to the allegation. The DOC indicated that they were aware of the immediate reporting requirements.

When the allegation of abuse was not immediately reported to the Director, the residents were at risk of not being protected from abuse.

Sources: Critical Incident Report, licensees' internal investigation, interview with LEC, AA and DOC. (623) [s. 24. (1)]

2. The licensee has failed to ensure that the person having reasonable grounds to suspect improper care of resident #012, that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident Report (CIR) was submitted to the Director the day after the allegations of neglect towards resident #012 were reported by the resident's Substitute Decision Maker (SDM). The CIR indicated that RPN #158 and RN #115 had spoken with the resident's SDM regarding the allegations of improper care and that the Director of Care (DOC) had been made aware of the allegations on the same day. The allegations of neglect of resident #012 by the resident's SDM were not immediately reported to the Director.

The RPN indicated they immediately reported allegations of staff to resident neglect towards resident #012 to RN #156. According to the RPN, the resident had been left sitting in their chair for six hours and had not received care or their scheduled bath on a specified date. The RPN reported the resident was crying when they entered the room and discovered the resident had not received care. Staff interviews and review of the plan of care identified the resident's continence care was not provided, as specified in the plan.

The DOC acknowledged they were aware of the allegations and immediate reporting requirements were not met and a CIR should have been immediately submitted to the Director when the allegations of abuse were reported by the RPN.

The allegations of staff to resident neglect and improper care was not reported to the Director and further incidents could occur without proper follow-up.

Sources: CIR, resident's plan of care and progress notes, interviews with staff and the DOC. [s. 24. (1)]

3. The licensee has failed to ensure that the person having reasonable grounds to suspect improper care of resident #018, that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

The Ministry of Long-Term Care received a complaint related to staffing shortages, care concerns with allegations of neglect due to continence care not being provided as directed in the resident's plan of care.

According to the complainant, they had evidence the resident had not received continence care for a period of ten hours. The resident's Substitute Decision Maker (SDM) reported they called the home and spoke with the RN to report their concerns. They further indicated the Director of Care (DOC) contacted them the next day to discuss the care concern brought forward to the RN.

The following day, the resident's SDM sent an email to the DOC alleging resident neglect due to allegations that the resident had been without continence care for eight, ten, and twelve hours. The resident's SDM further alleged that new employees were not aware of the resident's care needs and were not always following the resident's plan of care.

Staff interviews and review of the plan of care identified the resident should receive continence care at specified times. The Clinical Care Coordinator (CCC) indicated that complaints regarding resident care would be documented within a Critical Incident Report (CIR). They further indicated the licensee did have a complaint binder to log complaints and there was no record of complaints logged in this binder. An incident report regarding this situation or a call to the Ministry's after-hours line was not found and there was no report to the Director regarding the allegations of neglect that were reported to the DOC,

by email on the specified date.

The allegations of staff to resident neglect and improper care was not reported to the Director and further incidents could occur without proper follow-up.

Sources: Review of the resident's progress notes, the CIRs submitted by the home to the Director, the resident's SDM and DOC emails, interviews with staff, the CCC, and the resident's SDM. [s. 24. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a clinically appropriate pain assessment was completed when resident #016's pain was not relieved by initial interventions.

The licensee's pain policy directed to complete a comprehensive pain assessment to determine the type of pain and document a pain assessment when there were behaviours exhibited by a resident that may be an indicator for the onset of pain.

Non-compliance was identified with r. 52. (2) related to residents #001 and the sample size was expanded to include resident #016.

During the inspection, resident #016 reported to Inspector #601 that a specified area was very painful and wondered what was causing the pain.

PSWs indicated the resident had been reporting pain for a specified period of time and RPN #112, RN #157, the CCC acknowledged they were aware the resident was experiencing pain. RPN #122 indicated the resident's routine pain medication had been effective and the resident had not required the as needed pain medication. Registered staff interviewed indicated they had not completed a Pain Observation Tool (POT) assessment and RPN #112 indicated the POT assessment should have been completed. Staff documentation and interviews identified the resident required breakthrough pain medication on several occasions for pain management and the as needed pain medication administered was not always effective. The CCC acknowledged that the licensee's pain management policy directed staff to use the POT assessment when a resident's pain was not managed, and a POT assessment had not been completed for the resident.

A clinically appropriate pain assessment was not completed when the resident's pain was not relieved with the prescribed routine and as needed pain medication for several weeks. The resident was at risk of experiencing ongoing pain and the failure to assess the resident's pain when not relieved by initial interventions using a clinically appropriate assessment instrument presented a risk of overlooking aspects crucial to the resident's comfort.

Sources: Resident's progress notes, care plan, Pain and Symptom – Assessment and Management Protocol policy, Medication Administration Records, and Physician Orders, and interviews with the resident, PSWs, RPNs, RN, RPN/NM, and CCC. [s. 52. (2)]

2. The licensee has failed to ensure that resident #001 was assessed using a clinically appropriate assessment when the resident's pain was not relieved by the initial interventions.

The resident's SDM reported they had concerns that registered staff did not collaborate with the physician regarding the resident experiencing pain.

The resident was experiencing a specified pain for several weeks. The resident was prescribed routine and as needed pain medication. The plan of care directed to identify factors that may aggravate or alleviate pain and to consult with the physician if the medication ordered was ineffective. Staff documentation and interviews identified the resident required breakthrough pain medication on several occasions for pain management and the as needed pain medication administered was not always effective. Registered staff interviewed identified the resident's pain was not managed and they

were not aware of a Pain Assessment Tool being completed for the resident.

There was no evidence that a clinically appropriate pain assessment was completed for a specified period of time when the resident's pain was not relieved with the prescribed routine and as needed pain medication.

The resident was at risk of experiencing ongoing pain and a clinically appropriate pain assessment could have provided the resident's physician with a tool to identify, implement and monitor the medical interventions implemented to manage the resident's pain.

Sources: Pain and Symptom – Assessment and Management Protocol policy, Pain Observation Tool (POT), care plan, resident's progress notes, Medication Administration Records, and Physician Orders, interviews with PSW, RPN, RN, RPN/NM, CCC, and resident's SDM. [s. 52. (2)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

A complaint was submitted to the Ministry of Long-term Care which indicated concerns that residents were not being offered sufficient hydration.

A record review of residents #004, #008, #018 and #020 care plan identified that each resident was at risk for reduced fluid intake and was to receive additional fluids daily as per the Hydration Program. The plan of care identified for each resident that the Registered Dietitian and the Food Services Supervisor will monitor food and fluid intake. Review of the Dietary Report for food and fluids intake identified there were gaps in documentation for all four residents. The daily fluid intake totals were consistently below the identified requirements for each resident.

During separate interviews, the Acting Nutritional Care Supervisor, the Dietitian and Registered Nurses could not confirm who was responsible to review the residents nutritional intake records to identify any evaluation of the resident's or a change and decline in their fluid intake. They each confirmed that they were not doing it. The Dietitian indicated they would review the resident records quarterly but acknowledged that would be too late if the resident was experiencing dehydration.

During an interview the Director of Care (DOC) indicated the licensee’s expectation is that Registered Staff would review the PSW’s documentation each shift to ensure it has been completed and identify any residents who are consistently consuming less then the required food and fluid intake amounts. The DOC reviewed the intake records for resident’s #004, #008, #018 and #020 and confirmed that the documentation consistently identified that the residents were not consuming the required fluids but there was also inconsistent documentation including gaps so it was difficult to get a true sense of intake. The DOC indicated that if registered staff had concerns, they could always refer to the Dietitian at any time.

Residents were at risk of dehydration when the licensee failed to ensure there was a system in place to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Sources: Observations, care plans and dietary intake records, interview with staff, Hydration Program policy. [s. 68. (2) (d)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items were offered and available at each meal and snack.

A complaint was brought forward to the Ministry of Long-Term Care that residents were not being offered sufficient fluids.

Resident #004, #008, #018, and #020's nutrition care plan indicated that the residents were to be offered a specified amount of fluid at each meal and snack plus an additional amount of fluid per day outside of their meals and snacks. Resident #004, #008, #018, and #020's meal was observed on two specified dates, and the residents were not offered fluids according to their nutritional care plan. Review of the resident's total documented daily fluid intake for the specified dates identified that the residents' daily fluid needs according to their nutrition care plan had not been met.

Resident #018 was observed to be offered a nutritional supplement during their lunch meal on two specified dates. PSW #118 and PSW #137 confirmed that the nutritional supplement was from the morning and afternoon snack cart which had not been provided to the resident at their scheduled snack.

The residents were to be provided a specific amount of fluids outside of their meals and snacks and there was no evidence to support that the residents received the required fluid.

The planned menu for beverages/fluids was not offered to residents #004, #008, #018, and #020 when observed on two specified dates. This may have contributed to the residents not consuming their estimated fluid needs for the day.

Sources: Mealtime observations, resident care plan and dietary intake records, staff interviews, Hydration Program policy, facility menu plan. [s. 71. (4)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #008 was provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possibly.

Dining observations of resident #008 were completed on two specified dates. During the observation it was identified that staff placed two beverages on the table for resident #008. The resident was seated sideways to the table and appeared unaware that the beverages were available. Throughout the meal staff did not attempt to place the glass in the resident’s hand or assist the resident by holding the glass so they could consume the beverage. There were no fluids consumed throughout either meal by resident #008.

During an interview the Acting Nutritional Care Supervisor indicated that the staff should have assisted the resident with the beverages or the beverages should be placed into a cup with an assistive device so that the resident could safely drink without spilling the beverage. Review of the care plan for resident #008 identified staff were to provide extensive assistance including physical help throughout the meal encouraging intake and assisting with intake as needed.

When the staff failed to provide resident #008 with an assistive device or personal assistance to safely drink as comfortably and independently as possible, the resident was at risk of not meeting their required daily fluid intake.

Sources: Observations, care plan, staff interview [s. 73. (1) 9.]

2. The licensee has failed to ensure that proper techniques were used to assist a resident with eating, including safe positioning of residents who require assistance.

A meal time observation was conducted on two specified dates, which identified resident's #004, #008, 018, and #020 were not seated in a safe position for eating and drinking purposes, while being assisted to eat their meal. Record review of each of the resident's written plan of care indicated they were each at risk when not seated safely. During separate interviews, a PSW, RCA and RN indicated that residents #004, #008, 018 and #020 should have been seated in a safe position during food and fluid intake.

Resident's #004, #008, #018 and #020 were at risk of a negative outcome when they were not positioned safely when eating.

Sources: Observations, resident care plans, staff interviews. [s. 73. (1) 10.]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program (IPAC) related to staff adherence to safely apply and remove Personal Protective Equipment (PPE), and hand hygiene (HH).

The signage outside of resident #022's room indicated the resident required contact and droplet precautions and there was no eye protection located in the isolation cart outside of the resident's room. PSW #148 did not perform hand hygiene prior to applying the gloves and gown or apply eye protection prior to entering the resident's room. The PSW assisted the resident with care and reported that eye protection was not required as the resident was on contact precautions. Inspector #601 discussed the signage indicating the requirement for eye protection and a second staff member brought the eye protection. The CCC confirmed that resident #022 was on contact and droplet precautions and staff should have applied eye protection prior to entering the resident's room.

Observations of staff during the inspection by Inspector #601 and Inspector #623 identified staff were not always assisting residents with HH before and after meals. Staff did not always perform HH before and after providing resident direct care. Staff interviewed confirmed they had received education and residents should receive assistance with HH before and after meals, and staff should perform HH before and after providing resident direct care. The CCC indicated that all staff received education on "Just Clean Your Hands - Your 4 Moments for Hand Hygiene" program. The CCC also indicated an auditing process was in place for evaluating staff compliance with HH. Review of the Just Clean Your Hands Program "Your 4 moments for Hand Hygiene" required staff to assist residents to perform HH before and after meals and snack. Staff were also required to complete hand hygiene before initial resident and after resident environment contact.

Multiple beverages were observed at the nursing station and staff were observed to be eating and drinking in resident common areas. A PSW was observed to have a water bottle at the nurse's station, they removed their mask by placing under their chin and took a drink, no hand hygiene was performed prior to touching their mask.

The residents were at actual risk for transmission of infection when staff failed to properly apply the PPE and ensure that staff consistently performed HH when performing direct care and offer residents HH before and after meals.

Sources: Observation of staff IPAC practices, Best Practices for Hand Hygiene in all Health Care Settings, 4th edition, April 2014, Public Health Ontario (PHO) - Universal Mask Use in Health Care Settings and Retirement Homes, February 10, 2021, interviews with PSWs, RPNs, RNs, HSKs, and the CCC. [s. 229. (4)]

2. The licensee has failed to ensure that staff recorded resident #013's symptoms of

infection on every shift and that immediate action was taken when required.

The resident's physician prescribed an antibiotic to be administered daily as a preventative measure to treat an infection. There was no evidence there was any follow up regarding the resident's symptoms of infections and there was no system in place to ensure staff recorded the resident's symptoms of infection on every shift. The resident's progress notes on two specified dates indicated the resident was experiencing signs of an infection. Staff acknowledged they did not record symptoms of infection on every shift and were not aware of the requirement to record symptoms when a resident had an infection. There was also no evidence that immediate action was taken when the resident was experiencing symptoms of an infection, on two specified dates. The resident was at risk for discomfort and complications when the resident's infections were not assessed on every shift to determine if the antibiotic treatment was required or effective with treating the resident's health status.

Sources: The resident's care plan, progress notes, lab reports for 2021, Medication Administration Record, physician orders, interviews with PSWs, RN, CCC, and the DOC. [s. 229. (5) (b)]

3. The licensee has failed to ensure that staff recorded resident #016's symptoms of infection on every shift and that immediate action was taken when required.

Non-compliance was identified with r. 229. (5) (b) related to resident #001 and the sample size was expanded to include resident #016.

The resident's progress notes identified the resident had impaired skin integrity on specified dates several weeks earlier and for several days prior to the physician prescribing a medicated cream for a specified number of days to treat the resident's skin infection. The documentation indicated the resident had impaired skin integrity after the completion of the medicated cream. There was also no evidence that immediate action was taken on the specified date when the resident experienced symptoms of an infection nor that the symptoms were evaluated to determine if the medicated cream prescribed for a specified number of days was effective. The resident experienced symptoms of an infection following the treatment and there was no evidence follow up action was taken. The resident was at risk for discomfort when the resident's infection was not assessed, and symptoms were not recorded on every shift to determine if the medicated cream was effective in treating the resident's impaired skin integrity. Staff acknowledged they did not record symptoms of infection on every shift and were not aware of the requirement to

record symptoms when a resident had an infection.

The resident's progress notes identified the resident had symptoms of a different infection as the resident reported symptoms of an infection. Resident #016's physician prescribed an antibiotic to treat the infection for a specified period of time. Staff indicated the resident had a history of infections and the resident was able to communicate to staff when they were experiencing symptoms. The resident was at risk for discomfort and complications when the resident's infection was not assessed, and symptoms were not recorded on every shift to determine if the antibiotic was effective with treating the resident's infection. Staff acknowledged they did not record symptoms of infection on every shift and were not aware of the requirement to record symptoms when a resident had an infection.

Sources: The resident care plan, progress notes, Head to Toe Skin Bath Assessments, lab reports for 2021, Medication Administration Record, physician orders, interviews with PSWs, RPNs, RN #157, and CCC. [s. 229. (5) (b)]

4. The licensee has failed to ensure that staff recorded resident #029's symptoms of infection on every shift and that immediate action was taken when required.

Non-compliance was identified with r. 229. (5) (b) related to resident #001 and the sample size was expanded to include resident #029.

The resident's progress notes indicated the resident had a decline in condition and symptoms of infection for a week prior to the physician prescribing an antibiotic for specified period of time. CCC #102 confirmed that the resident had an infection. Staff acknowledged they did not record symptoms of infection on every shift and were not aware of the requirement to record symptoms when a resident had an infection.

The resident was at risk for discomfort when immediate action was not taken to assess the resident's change in condition and potential complications when the resident's infection was not assessed, and symptoms were not recorded on every shift to determine if the antibiotic was effective with treating the resident's infection.

Sources: The resident's care plan, progress notes, Medication Administration Record, and interview with CCC #102. [s. 229. (5) (b)]

5. The licensee has failed to ensure that staff recorded resident #001's symptoms of

infection on every shift and that immediate action was taken when required.

A complaint was submitted to the Ministry of Long-term Care which indicated concerns that the resident was not receiving continence care according to their plan of care and their infections were not being managed.

The resident's SDM suspected the resident had an infection for a specific month and requested a lab test be completed on two specified dates. The physician ordered the lab test on three different dates and the specimen was collected and sent to the lab a week after the physician ordered the lab test.

The resident was prescribed antibiotics during the specific month for a specified period of time. There was no further documentation to indicate that the resident's infection was assessed on every shift. Registered staff interviewed indicated they did not routinely record symptoms or assess the resident for symptoms of infection, on every shift while the resident was prescribed an antibiotic. They further indicated they would document in the resident's progress notes if a PSW reported and signs or symptoms.

The resident was at risk for discomfort and complications when immediate action was not taken and the resident's infections were not assessed on every shift to determine if the antibiotic treatment was effective with treating the resident's infection status.

Sources: Life lab reports, physician orders, Medication Administration Records, progress notes, Interviews PSWs, RPNs and the resident SDM. [s. 229. (5) (b)]

Additional Required Actions:

CO # - 009, 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the staffing mix was consistent with the residents' assessed care and safety needs when ten residents did not receive continence care according to their assessed needs.

Five complaints with concerns that staffing shortages resulted in residents not receiving scheduled continence care and allegations of resident neglect was submitted to the Ministry of Long-term Care.

Multiple staff and family members reported they were concerned the residents were not receiving proper care due to the limited amount of time and staff to provide the residents' care. Staff indicated the staffing schedule and the daily staffing sheets were not kept up to date and they did not reflect the actual staffing shortages. They further indicated that modified staff were not always replaced, and this affected resident care as the modified staffs' ability to assist with resident care was limited. Staff further reported they often worked with agency staff who were not familiar with the residents' plan of care. Staff interviewed indicated they were exhausted from the extensive workload and from working overtime due to the staffing shortages.

Please refer to the area of non-compliance identified within this report related to s. 6 (7) of the LTCHA regarding staffing shortages that were conveyed as the reason the licensee failed to provide the individualized plan of care for residents #001, #012, #013, #014, #016, #017, #018, #021, #026, and #028 to promote and manage bowel and bladder continence based on the residents' assessment and the delay in continence care resulted in the residents going a significant length of time without continence care placing the residents' at risk for impaired skin integrity and urinary tract infections.

There were 99 residents residing in the home at the time of this inspection. Review of the staffing plan identified that 102 residents required fourteen PSWs to work on the day shift, eleven PSWs to work on the evening shift and six PSWs to work on the night shift. Review of the daily staffing sheets and interview with the Director of Care (DOC) identified that attempts were being made to increase the evening staffing levels from three PSWs to four PSWs working on the third floor.

Review of the 2020 Evaluation of Staffing Plan identified that if a shift goes unfilled staff were relocated based on the resident needs for the shift. The charge nurse checks the staffing levels at the beginning of the shift and relocates the staff based on the resident needs for the day. Review of the 2021 Evaluation of Staffing Plan identified COVID-19 had affected the staffing levels due to increased staff call ins and not being able to share staff between health care facilities.

Inspector #601 reviewed the staffing schedule, daily staffing sheets and the staff entering the home based on the COVID-19 screening records from June 13 to July 9, 2021. Inspector #601 was not able to accurately determine who had worked during this time nor the location where the staff had worked. The documentation provided by the DOC showed that there was a total of 43 out of 81 PSW shifts that were not covered as per the homes staffing plan from June 13 to July 9, 2021. There were several night shifts when there was one registered practical nurse (RPN) responsible for all the residents in the home. The DOC acknowledged the staffing schedule and daily staffing sheets provided to Inspector #601 may not reflect the actual staffing levels and the staffing levels were often below the planned staffing complement. According to the DOC, the staffing plan directs the charge nurse to review the residents care needs when there are staffing shortages and redirect staff work locations based on the resident needs. They further acknowledged that modified staff were not always replaced nor able to assist with resident care and would remain on the staffing schedule. The DOC further indicated attempts for staff recruitment was ongoing and as of July 13, 2021 there were ten to twelve PSW part-time positions that remained vacant. There was one RN part-time night

line and one RPN part-time night line vacant. According to the DOC, several agency staff have been working in the home and efforts have been made to provide continuity of resident care.

The licensee has not been able to recruit and retain staff according to the home's staffing plan and there was actual risk of harm when several residents' assessed care needs according to the staffing plan was not met when the home does not have the full complement of staff working. Staffing shortages in the home puts the residents at risk due to the staff reporting they don't have enough time to provide proper care to the residents. The staff report they do their best to provide care to the residents, but they need to take short cuts putting the residents and themselves at risk for injury.

Further, the shortage of staff and its impact on residents not receiving care according to the plan of care, including continence care or delayed care demonstrates that the licensee did not ensure that residents assessed care needs were met.

Sources: Review of several residents clinical health records, Master Schedule, Daily Staffing Sheets, Staffing plan for 2020, Evaluation of Staffing Plan 2020/2021, interviews with PSWs, RCAs, RPNs, RN's, AA's, HSKs, DAs, RAI Coordinator, CCC, Admin A, LEC, and DOC. [s. 31. (3)]

Additional Required Actions:

CO # - 012 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

The Director received five complaints from residents' Substitute Decision Makers (SDMs) and staff regarding staffing shortages, care concerns with allegations of resident neglect due to improper care. Interviews with the residents' SDMs and multiple staff identified they had reported their concerns regarding the residents not receiving care due to staffing shortages to management. They further indicated the staffing shortages were ongoing and they did not feel there was a resolution to their complaints. The licensee was not able to provide a documented record of complaints concerning resident care or the operation of the home, verbal or written for 2021. The Clinical Care Coordinator (CCC) indicated the Director of Care (DOC) would complete a Critical Incident Report (CIR) when there were allegations of abuse and there was also a complaint logbook. According to the CCC, there were no complaints documented in the logbook for 2021 to indicate a complaint concerning resident care or the operation of the home, verbal or written had been received.

There was a risk that the licensee was not addressing or resolving complaints concerning resident care or the operation of the home, verbal or written when the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant was not documented in 2021.

Sources: Review of resident #001, #012, and #018's progress notes and CIRs submitted to the Director, interviews with PSWs, RPNs, RNs, CCC and residents' SDMs. [s. 101. (2)]

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 a documented record was kept in the home that included the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #016's drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

A PSW indicated the resident had impaired skin integrity and the resident reported the area was sore. The PSW had been applying the as required medicated cream that was stored in the resident's room. The resident reported the medicated cream was improving their skin condition and the PSWs had been applying the medicated cream. There was no documented record that the resident's medicated cream had been applied by the PSWs or that a registered staff had completed a skin assessment. RPNs and the CCC indicated they were not aware the resident had impaired skin integrity nor that the medicated cream was being applied by the PSWs.

There was a risk to the resident when the registered staff were not assessing the resident's impaired skin integrity and that the PSWs were applying the medicated cream without the knowledge of the registered staff. By not ensuring the medicated cream was stored in an area or medication cart that was kept secured and locked placed the resident at risk for the medicated cream being applied without the knowledge of the prescriber.

Sources: Room observations, interviews with the resident, PSWs, RPNs and CCC. [s. 129. (1) (a)]

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 shall ensure that (a) drugs are stored in an area or a medication cart, (i) that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

Issued on this 5th day of October, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	KARYN WOOD (601), SARAH GILLIS (623)
Inspection No. / No de l’inspection :	2021_885601_0015
Log No. / No de registre :	006409-21, 007517-21, 007883-21, 007890-21, 008190-21, 010958-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 23, 2021
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

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

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5 of the LTCHA.

Specifically, the licensee must:

1. Ensure all staff maintain infection prevention and control measures specified in Directive #3 regarding the proper use of universal masking, including in administrative areas, and maintaining two meters distance from others while not wearing a mask.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe environment related to the failure to maintain infection prevention and control measures specified in Directive #3 regarding the proper use of eye protection, medical mask, and maintaining two meters distance from others while not wearing a mask.

Staff were observed without eye protection, wearing eye protection on their forehead, and with eye protection that was not government approved for Personal Protective Equipment (PPE) when they were within two meters of a resident. Physical distancing was not being maintained and several staff were observed to be within two meters of others with no medical procedure mask or with the mask not covering their mouth and/or nose.

The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to long-term care homes and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in long-term care homes. As per

Directive #3 from June 9 to July 16, 2021, all staff of long-term care homes were required to wear eye protection when they were within two meters of a resident. Staff are always to comply with universal masking, even when they are not delivering direct patient care, including in administrative areas. During their breaks, to prevent staff to staff transmission of COVID-19, staff must always remain two meters away from others and be physically distanced before removing their medical mask for eating and drinking. Masks must not be removed when staff are in contact with residents and/or in designated resident areas. The mask must be covering their nose and mouth. The Hastings Prince Edward Public Health Nurse confirmed the staff should be wearing their mask covering their nose and mouth, as per Directive #3.

The lack of adherence to Directive #3 related to the use of eye protection, universal mask use and physical distancing presented an actual risk of exposing the residents to COVID-19.

Sources: Directive #3 (version effective date June 9, 2021 and July 16, 2021), observations throughout the home by Inspector #601 and Inspector #623 and interview with Hastings Prince Edward Public Health Nurse. [s. 5.]

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

Severity: There was actual risk to residents when Directive #3 was not followed by staff related to universal masking and physical distancing as the residents could potentially be exposed to COVID-19.

Scope: The scope of this non-compliance was widespread as physical distancing was not being maintained and staff were observed to be within two meters of others with no surgical procedure mask or with the mask not covering their mouth and/or nose in several areas throughout the home.

Compliance History: One previous Voluntary Plan of Correction was issued to the home under the same subsection of the legislation within the previous 36 months. (601)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 14, 2021

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 : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee must be compliant with s. 6 (4)(a) of the LTCHA.

Specifically, the licensee must:

1) Develop and implement a process with written strategies for all registered staff to follow that provides details on when to communicate a change in a resident's condition with the physician, dietitian, physiotherapist, and the resident's Substitute Decision Maker (SDM). The strategies are to include but not limited to, who is responsible to notify the physician, dietitian, physiotherapist, and the resident's SDM, the actions required to assess the resident, any follow up action required and where to document the communication with the physician, dietitian, physiotherapist, and the resident's SDM.

2) Educate the registered staff on the process and written strategies to follow when a resident has a change in condition so that their assessments are integrated, consistent with and complement each other when revising the plan of care for a resident. Keep a documented record of the education provided and staff attendance.

Grounds / Motifs :

1. The licensee has failed to ensure that staff collaborated with the physician

and each other when resident #016 was experiencing impaired skin integrity so that their assessments were integrated, consistent with and complemented each other.

Non-compliance was identified with s. 6. (4) (a) related to a resident and the sample size was expanded to include resident #016.

The resident's progress notes identified the resident had impaired skin integrity for several days prior to the physician prescribing a medicated cream for a specified number of days to treat the resident's impaired skin integrity. The documentation indicated the resident had impaired skin integrity after the completion of the medicated cream and prior to the inspection. During the inspection, the resident reported they had skin discomfort and that staff had been applying a medicated cream. A PSW indicated the resident had impaired skin integrity and they had reported to registered staff that they had applied the medicated cream. Registered staff interviewed acknowledged the resident's specified area was prone to impaired skin integrity but they were not aware the resident was reporting skin discomfort nor that PSWs were applying the medicated cream at the request of the resident.

There was no evidence that staff had collaborated with the physician regarding the resident's impaired skin integrity until several days after the skin impairment was first documented and the physician prescribed the medicated cream to treat the resident's skin infection. The resident was at risk for discomfort and further impaired skin integrity when the registered staff and physician were not aware that the resident was experiencing impaired skin integrity at the time of this inspection and that the PSWs were applying a medicated cream that was prescribed to be applied when required.

Sources: Resident's care plan, progress notes, care plan, Head to Toe Skin Bath Assessments, Medication Administration Record, physician orders, interviews with PSWs, RPNs, RN, and the CCC. [s. 6. (4) (a)] (601)

2. The licensee has failed to ensure that staff collaborated with the physician and each other when resident #001 was experiencing pain, and symptoms of an infection so that their assessments were integrated, consistent with and complemented each other.

A complaint was submitted to the Ministry of Long-Term Care with allegations that the resident's pain and infections were not be managed.

The resident's SDM reported they had concerns that registered staff did not collaborate with the physician regarding the resident experiencing pain, symptoms of infection and their request for a medical test.

The resident's SDM requested a lab test be completed as the resident had a change in health condition. RPN #114 documented the resident had a bit of pain, and that the PSW and the resident's SDM reported the resident had complained of pain in the past and a note was left in the physician's book requesting a medical test. A few days after the resident's SDM's requested the lab test and medical test, RPN #124 documented they had consulted with the charge nurse regarding the resident's pain and the SDM's request for a medical test. RPN #124 documented they were not aware of the resident experiencing specified pain but the PSWs reported the resident often reported pain. PSW #121 indicated they had reported to the registered staff that the resident was experiencing pain and the resident's pain was not managed. RPN #114 indicated the resident received pain medication regularly that was not always effective. RPN #114, Clinical Care Coordinator (CCC), and the nurse manager (RPN/NM) indicated they were not aware of the physician being informed of the resident experiencing the pain until the medical test was ordered by the physician which was several weeks after the resident's SDM's initial request.

The resident's SDM suspected the resident had an infection and requested a lab test be completed on two specified dates. The physician ordered the lab test on a few different dates and the specimen was collected and sent to the lab a week after the physician ordered the lab test. The specimen was sent to the lab several weeks after the resident's SDM's requested and the results of the lab test were positive for an infection.

There was no evidence that staff collaborated with the physician when the resident was experiencing pain and symptoms of infection for several weeks. The resident was at risk for discomfort and complications of infection when registered staff did not collaborate with the resident's physician regarding the resident experiencing pain and symptoms of infection.

Sources: Review of resident progress notes, plan of care, Signs and Symptoms of Infection, policy, Life lab reports printed, physician orders, interviews with PSW, RPN, RPN/NM, CCC, and the resident's SDM. [s. 6. (4) (a)] (601)

3. The licensee has failed to ensure that staff collaborated with the physician, Dietitian, Physiotherapist, and each other when resident #018 was having difficulties with eating and decreased nutritional intake so that their assessments were integrated, consistent with and complemented each other.

A complaint was brought forward to the Ministry of Long-Term Care that the resident was not being offered sufficient fluids.

Inspector #623 observed the resident during their meal and identified the resident was not positioned properly during their meal. Review of the care plan identified the resident was to be positioned in a full sitting position during meals.

The resident was having difficulties eating and taking their medication, was refusing to eat and the resident's Substitute Decision Maker (SDM) reported the resident had decreased nutritional intake. The following week, the resident's SDM requested the resident be assessed by a specialist and that the physician be notified that the resident had decreased nutritional intake and difficulties with eating. The RN documented their assessment of the resident and that a note would be left for the physician to assess during their next visit. The following week, the RPN documented their assessment of the resident. The RPN contacted the resident's SDM and discovered the resident's SDM had previously requested the physician assess the resident for the issue being identified by the RPN. The following week, the resident started on medication to treat an infection. The RPN documented the resident's SDM requested for a medical test and that a referral to a specialist. The resident's SDM was informed the medical test for the resident had been ordered by the physician two days earlier.The resident's SDM indicated they had not been made aware of the new orders and requested an explanation from the charge nurse. The following week, RPN/NM documented in the resident's progress notes that the resident's SDM was notified the specialist referral would be completed within the week as the physician wanted the resident's infection to clear up and the medical test to be completed prior to referring to the specialist.

The Dietitian indicated to Inspector #623 that they were not aware of the resident's difficulties with eating, decreased nutritional intake or that the resident's SDM had requested the resident be assessed by a specialist. CCC #102 confirmed that a referral had not been made to the Dietitian regarding the resident's decreased nutritional intake, difficulties with eating and that a referral had not been made to the Physiotherapist to assess the residents positioning during meal service.

There was no evidence that staff collaborated with the physician, Dietitian, or Physiotherapist when the resident's SDM requested the resident be assessed three times nor that the staff communicated the physicians findings to the resident's SDM when the physician had prescribed medication to treat the resident's infection.

The resident was at risk for a negative outcome when they were not properly positioned during meals and collaboration with the Physiotherapist would allow for a proper seating assessment. The resident's difficulties with eating were first noted by staff and the resident's SDM several weeks before the physician was made aware and this placed the resident at risk for decreased nutritional intake and discomfort as they were not able to communicate the reason they were having difficulties with eating.

Sources: Resident's progress notes, care plan, physician orders, Medication Administration Record, and interviews with RPN/NM, CCC, and resident's SDM. [s. 6. (4) (a)]

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

Severity: There was a risk of harm when registered staff did not collaborate with the physician and each other when the residents had a change in condition that involved difficulties with eating, decreased nutritional intake, unmanaged pain, symptoms of an infection and impaired skin integrity.

Scope: The scope of this non-compliance was widespread as three out of three residents were at risk when registered staff did not collaborate with the residents' physician when the residents had a change in condition.

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

Compliance History: One previous Written Notification was issued to the home under the same subsection of the legislation within the previous 36 months. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 31, 2022

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 : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the LTCHA.

The licensee will prepare, implement, and submit a plan outlining how they will obtain compliance and protect residents from abuse and neglect. The plan will include but not be limited to the following elements:

1) Review this order with all staff.
2) Develop a system which includes training supervisory staff to monitor the following:
-Monitoring and intervening staff to resident interactions during provision of care
-Monitoring the deployment of staff on the individual units to ensure resident needs are met.
-Monitoring staff for situations that may lead to abuse and neglect.
3) Document roles and responsibilities; time lines; supervisor training records; and monitoring records and outcomes.

Please submit the plan to CentralEastSAO.MOH@ontario.ca, Attention: Karyn Wood, Inspector #601 by October 4, 2021.

Grounds / Motifs :

1. The licensee has failed to protect residents #004, #005, #006, #007, #008 and #009 from physical, and verbal abuse.

A Critical Incident Report (CIR) related to allegations of staff to resident physical and verbal abuse was submitted to the Ministry of Long-term Care.

Under O.Reg. 79/10 s.2. (1) For the purposes of the definition of "abuse" in

subsection 2 (1) of the Act,

"verbal abuse" means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident,

"physical abuse" means, subject to subsection the use of physical force by anyone other than a resident that causes physical injury or pain.

The CIR was submitted to the Director for allegations of abuse by PSW #125 and PSW #126 towards resident's #004, #005, #006, #007, #008 and #009.

Review of the licensee's internal investigation identified the following incidents had been ongoing over a period of approximately three months:

Resident #004 – Staff reported to observe PSW #126 be physically and verbally aggressive when providing care, yell at the resident "come on, move your arm" and flip them when providing care. PSW #152 reported that PSW #126 would refuse to lay resident #004 down and they were only ever toileted once in the shift.

Resident #005 – PSW #127, #128, #150 and #152 each reported that when providing care to resident #005, PSW #125 and #126 would pull their mask down, point to their cheek and say to the resident "hit me right here, then I can go home". PSW #128 reported that PSW #126 indicated they would say this to resident #005 to "control their behaviour". PSW's indicated that once the resident was up in the morning which was usually around 0600 hour, care was not provided again until bedtime.

Resident #006 – PSW #128 and #150 each reported that PSW #126 would forcefully push resident #006 down into the bathtub while the resident was screaming "no, no, no". PSW #126 would say "you have to have a bath".

Resident #007 – During an interview with resident #007, the resident reported that two to three PSW's were always very short with the resident when providing morning care and expressed concerns that other residents were also being

treated the same way. The resident declined to name the PSW's. PSW's #128 and #150 reported that PSW's #125 and #126 would speak in an aggressive manner to resident #007. They would tell the resident they didn't have time to complete a task after the resident's bath, would grab the resident roughly causing the resident to say "ouch". PSW #150 also reported that PSW #126 would refuse to provide care to resident #007 stating that the resident had a behaviour and "there were more important resident's that needed care". PSW #127 reported that when resident #007 spilled a beverage on their pants, PSW #125 refused to assist the resident to be changed stating "Are you kidding me, I don't have time for this". The housekeeper assisted PSW #127 to change resident #007.

Resident #008 - PSW #152 reported that when assisting PSW #126 to provide care to resident #008, the resident was very vocal. PSW #126 told resident #008 to "shut up and stop talking". Activation Aide (AA) #133 reported to have observed PSW #126 grab resident #008's hand out of the air and force it down. The PSW would speak to the resident in a harsh tone.

Resident #009 – AA #151 reported that resident #009 was in the dining room and requested to go to the bathroom, PSW #125 told the resident to "go in their brief", they didn't have time to take them to the bathroom.

The investigation interviews indicated that PSW #125 and #126 each confirmed the allegations against them. The PSW's indicated they were frustrated with working short staffed or being partnered with staff who were unable to perform all of the required duties.

During separate interviews Life Enrichment Coordinator (LEC) #132 and Administrative Assistant (AdminA) #145 indicated that they conducted the initial incident investigation together. During the interview, resident #007 was reluctant to identify the staff by name for fear of retaliation. The resident did confirm that there were two to three staff who were impatient and rushed when care was provided and didn't always complete all tasks. The LEC and AdminA both confirmed that during the investigation interviews, it was revealed by staff who were interviewed, the abuse had been ongoing for approximately three months, and the frontline staff who were aware of it did not report the incidents. The frontline staff indicated they were fearful of retaliation from PSW #125 and

#126 if they had reported the incidents. The registered staff seemed unaware that the incidents had occurred.

During an interview the Director of Care (DOC) indicated that any alleged, suspected or witnessed abuse of a resident is to be immediately reported. The DOC indicated that in 2020 all staff had not received any training related to the homes abuse policy which includes the duty to report, until after this incident investigation was completed in December 2020. The education was provided to staff during a staff meeting and as a read and sign of the policy which was attached to their pay stubs. The DOC was unaware of when any education had been provided prior to that date. The DOC indicated the outcome of the licensee's investigation confirmed that actual abuse towards resident's #004, #005, #006, #007, #008 and #009 by PSW #125 and #126 did occur.

Residents #004, #005, #006, #007, #008 and #009 were at risk of ongoing actual abuse by PSW #125 and PSW #126 when frontline staff were aware of the abuse and did not report it for approximately three months. The residents were repeatedly subjected to physical and verbal abuse, refusal of care to be provided, instructed to "go in their brief" when asked to use the bathroom, exposed to staff who pulled down their mask within close proximity to the resident, and told to punch staff so that the staff could go home.

Sources: Critical Incident Report, internal investigation documents, interviews with staff. (623) [s. 19. (1)] (601)

2. The licensee has failed to protect residents #012, #013, #014, #017, #018, #021, and #026 from neglect when continence care was not provided to the resident, as specified in the plan.

For the purposes of the Act and this Regulation:

"neglect" means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Multiple staff and family members reported they were concerned the residents

were not receiving proper care due to the limited amount of time and staff to provide the residents' care. Staff interviewed indicated they were exhausted from the extensive workload and from working overtime due to the staffing shortages.

Three residents indicated there were times when staff were not able to assist them with toileting assistance when requested, as the staff reported there were staffing shortages and they didn't have the time. Two of the resident's reported they were able to request staff assistance for toileting and there were times when they would be incontinent as the staff reported they didn't have time to provide the assistance. A resident further indicated agency staff were not always aware of their care needs, staff rush during care and they felt bad because they needed extra time with care, but they were not able to assist with their care due to their physical limitations.

The Ministry of Long-Term Care received two complaints related to staffing shortages, care concerns with allegations of neglect due to care not being provided as directed in the resident's plan of care. Resident #012's care plan related to continence care directed for the resident to receive total assistance from two staff. The RPN reported the resident was crying when they entered the room and discovered the resident had not received care from 0600 hour to 1200 hour. Staff failed to provide the assistance required to resident #012 as continence care was not provided for six hours on a specified date and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #013's care plan related to continence care directed for the resident to receive extensive assistance from two staff. PSW #108 reported resident #013 received continence care at 1400 and 1900 hour, on a specified date due to staffing shortages. According to the PSW, the resident's incontinent product was saturated with urine and the resident was a high risk for urinary tract infections. PSW #111 reported the resident received continence care prior to 0700 hour and that they did not have time to provide the resident's care after breakfast or before lunch, on a specified date due to staffing shortages. The DOC confirmed there were staffing shortages on the two specified shifts. Staff failed to provide the assistance required to resident #013 as continence care was not provided for five hours on two specified dates and this placed the resident at risk for

impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #014's care plan related to continence care directed for the resident to receive total assistance from two staff. PSW #108 reported resident #014 received care once on their shift at 2100 hour, on a specified date. According to the PSW, the resident's incontinent product was saturated with urine and the resident had been incontinent of stool. PSW #111 reported the resident received continence care prior to 0700 hour and that they did not have time to provide the resident's care after breakfast or before lunch at 1215 hour due to staffing shortages. The DOC confirmed there were staffing shortages on the two specified shifts. Staff failed to provide the assistance required to resident #014 as continence care was not provided for seven hours on a specified date, and for five hours on a specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #017's care plan related to continence care directed for the resident to receive total assistance from two staff. PSW #111 reported the resident received continence care prior to 0700 hour and that they did not have time to provide the resident's care after breakfast or before lunch on a specified date due to staffing shortages. The DOC confirmed there were staffing shortages on the specified shift and that they were not aware of any residents not receiving continence care. Staff failed to provide the assistance required to resident #017 as continence care was not provided for five hours on a specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

The Ministry of Long-Term Care received a complaint related to staffing shortages and that the resident had not received continence care for ten hours. Resident #018's care plan related to continence care directed for the resident to receive total assistance from two staff. On the specified date, the PSW working on the day shift completed POC documentation at 1037 hour and the documentation indicated the resident had been toileted once on the day shift and the PSW working on the evening shift completed the documentation at 1946 hour and the documentation indicated the resident had been toileted three times on the evening shift. The DOC indicated they were aware of the allegations from

the resident's SDM and the charge RN had interviewed the PSW working the evening shift on the specified date, and it was reported the resident had received continence care at 1500 hour. The resident's SDM reported they had evidence that the resident's continence care was not provided for ten hours, record review and staff interviews indicated the resident had not received continence care for four and a half hours. Staff failed to provide the assistance required to resident #018 as continence care was provided once on the day shift on the specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #021's care plan related to continence care directed for the resident to receive limited assistance from one staff. PSWs reported that resident #021 had not received morning care due to staffing shortages on a specified shift. The PSWs acknowledged there was no communication from the night shift regarding when the resident had last received continence care. The RAI Coordinator confirmed at 0930 hour, that resident care and meal service was behind on the resident's specified floor due to staffing shortages. Staff failed to provide the assistance required to resident #021 as continence care was not provided for four hours on the specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #026's care plan related to continence care directed for the resident to receive total assistance from two staff. PSWs reported that resident #026 had not received morning care due to staffing shortages on a specified shift. The PSWs acknowledged there was no communication from the night shift regarding when the resident had last received continence care and they had started their shift at 0600 hour. The RAI Coordinator confirmed at 0930 hour, that resident care and meal service was behind on the resident's specified floor due to staffing shortages. Staff failed to provide the assistance required to resident #026 as continence care was not provided for four hours on the specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

The DOC indicated attempts for staff recruitment was ongoing and at the time of the interview there were several PSW part-time positions that remained vacant. There was also one RN part-time night line and one RPN part-time night line vacant. According to the DOC, several agency staff have been working in the

home and efforts have been made to provide continuity of resident care.

The licensee has not been able to recruit and retain staff according to the home's staffing plan and there was actual risk of harm that several residents' assessed care needs according to the staffing plan were not met when the home did not have the full complement of staff working. Staffing shortages in the home puts the residents at risk due to the staff reporting they don't have enough time to provide proper care to the residents. Staff are rushed and they can be short tempered while providing care or when asked to assist with care. The staff report they do their best to provide care to the residents, but they need to take short cuts putting the residents and themselves at risk for injury. Staff, residents, and their families reported they are worried about the safety of the residents due to staffing shortages, they are frustrated, and don't feel supported.

Further, the shortage of staff and its impact on residents not receiving care according to the plan of care, including continence care or delayed care demonstrates that the licensee did not ensure that residents assessed needs were met and that the residents were protected from neglect.

Sources: Review of several residents clinical health records, Master Schedule, Daily Staffing Sheets, Staffing plan for 2020, Evaluation of Staffing Plan 2020/2021, interviews with PSWs, RCAs, RPNs, RN's, AA's, HSKs, DAs, RAI Coordinator, CCC, Admin A, LEC, and DOC, residents and resident SDM's. [s. 19. (1)]

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

Severity: There was actual risk of harm when six residents were not protected from physical and emotional abuse and the shortage of staff and its impact on seven residents not receiving care according to the plan of care, including continence care or delayed care demonstrates that the licensee did not ensure that residents assessed care needs were met and that the residents were protected from neglect.

Scope: The scope of this non-compliance was widespread as a total of 13 residents were involved and the staffing shortages involved the entire home.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 19, 2021

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 : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 24. (1) of the LTCHA.

Specifically, the licensee must:

1. Immediately report any suspicion of abuse resulting in harm or risk of harm to the resident and the information upon which it was based to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff, that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A Critical Incident Report (CIR) was submitted to the Director for an allegation of abuse by PSW #125 and PSW #126 towards residents #004, #005, #006, #007, #008 and #009. The CIR indicated that PSW #127 reported the allegations to the Manager of Life Enrichment (LEC) #132.

During an interview LEC #132 indicated that PSW #127 had reported to the

Director of Care (DOC) that they were feeling bullied by PSW #125 and PSW #126. The LEC and Administrative Assistant (AdminA) #145 had been directed to conduct a preliminary investigation interview with PSW #127 to gather details of their allegation. During this investigation interview, the PSW reported the allegation of abuse towards multiple residents. This was the first time that PSW #127 had reported these allegations. The LEC indicated that they reported the information to the DOC and were instructed to interview all of the staff involved and the residents if able. Once all of the interviews were completed, the DOC took over the investigation. The LEC indicated that the DOC would have submitted the report to the Director.

During an interview the DOC indicated they submitted the CIR, once the allegations were confirmed and did not immediately report the allegation. The DOC indicated that they interviewed staff first to ensure that there was truth to the allegation. The DOC indicated that they were aware of the immediate reporting requirements.

When the allegation of abuse was not immediately reported to the Director, the residents were at risk of not being protected from abuse.

Sources: Critical Incident Report, licensees' internal investigation, interview with LEC, AA and DOC. (623) [s. 24. (1)] (601)

2. The licensee has failed to ensure that the person having reasonable grounds to suspect improper care of resident #012, that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident Report (CIR) was submitted to the Director the day after the allegations of neglect towards resident #012 were reported by the resident's Substitute Decision Maker (SDM). The CIR indicated that RPN #158 and RN #115 had spoken with the resident's SDM regarding the allegations of improper care and that the Director of Care (DOC) had been made aware of the allegations on the same day. The allegations of neglect of resident #012 by the resident's SDM were not immediately reported to the Director.

The RPN indicated they immediately reported allegations of staff to resident

neglect towards resident #012 to RN #156. According to the RPN, the resident had been left sitting in their chair for six hours and had not received care or their scheduled bath on a specified date. The RPN reported the resident was crying when they entered the room and discovered the resident had not received care. Staff interviews and review of the plan of care identified the resident's continence care was not provided, as specified in the plan.

The DOC acknowledged they were aware of the allegations and immediate reporting requirements were not met and a CIR should have been immediately submitted to the Director when the allegations of abuse were reported by the RPN.

The allegations of staff to resident neglect and improper care was not reported to the Director and further incidents could occur without proper follow-up.

Sources: CIR, resident's plan of care and progress notes, interviews with staff and the DOC. [s. 24. (1)] (601)

3. The licensee has failed to ensure that the person having reasonable grounds to suspect improper care of resident #018, that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

The Ministry of Long-Term Care received a complaint related to staffing shortages, care concerns with allegations of neglect due to continence care not being provided as directed in the resident's plan of care.

According to the complainant, they had evidence the resident had not received continence care for a period of ten hours. The resident's Substitute Decision Maker (SDM) reported they called the home and spoke with the RN to report their concerns. They further indicated the Director of Care (DOC) contacted them the next day to discuss the care concern brought forward to the RN.

The following day, the resident's SDM sent an email to the DOC alleging resident neglect due to allegations that the resident had been without continence care for eight, ten, and twelve hours. The resident's SDM further alleged that new employees were not aware of the resident's care needs and were not

always following the resident's plan of care.

Staff interviews and review of the plan of care identified the resident should receive continence care at specified times. The Clinical Care Coordinator (CCC) indicated that complaints regarding resident care would be documented within a Critical Incident Report (CIR). They further indicated the licensee did have a complaint binder to log complaints and there was no record of complaints logged in this binder. An incident report regarding this situation or a call to the Ministry's after-hours line was not found and there was no report to the Director regarding the allegations of neglect that were reported to the DOC, by email on the specified date.

The allegations of staff to resident neglect and improper care was not reported to the Director and further incidents could occur without proper follow-up.

Sources: Review of the resident's progress notes, the CIRs submitted by the home to the Director, the resident's SDM and DOC emails, interviews with staff, the CCC, and the resident's SDM. [s. 24. (1)]

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

Severity: There was minimal risk of harm to the residents by not ensuring the Director was immediately informed of every allegation of resident abuse and/or neglect.

Scope: The scope of this non-compliance was widespread as there was one reported incident with allegations of abuse involving six residents, another incident reported involving one resident that was not immediately reported and two further incidents that involved allegation of staff to resident neglect that were not reported to the Director.

Compliance History: Three previous Voluntary Plans of Correction were issued to the home under the same subsection of the legislation within the previous 36 months. (601)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 19, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must be compliant with s. 52 (2) of O. Reg. 79/10.

Specifically, the licensee must:

1. Educate all registered staff in the home regarding the pain management program and include the directions for registered staff to take when a resident's pain is not relieved by initial interventions, the resident is to be assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

2. Keep a documented record of all education provided and staff attendance.

Grounds / Motifs :

1. The licensee has failed to ensure that a clinically appropriate pain assessment was completed when resident #016's pain was not relieved by initial interventions.

The licensee's pain policy directed to complete a comprehensive pain assessment to determine the type of pain and document a pain assessment when there were behaviours exhibited by a resident that may be an indicator for the onset of pain.

Non-compliance was identified with r. 52. (2) related to residents #001 and the sample size was expanded to include resident #016.

During the inspection, resident #016 reported to Inspector #601 that a specified

area was very painful and wondered what was causing the pain.

PSWs indicated the resident had been reporting pain for a specified period of time and RPN #112, RN #157, the CCC acknowledged they were aware the resident was experiencing pain. RPN #122 indicated the resident's routine pain medication had been effective and the resident had not required the as needed pain medication. Registered staff interviewed indicated they had not completed a Pain Observation Tool (POT) assessment and RPN #112 indicated the POT assessment should have been completed. Staff documentation and interviews identified the resident required breakthrough pain medication on several occasions for pain management and the as needed pain medication administered was not always effective. The CCC acknowledged that the licensee's pain management policy directed staff to use the POT assessment when a resident's pain was not managed, and a POT assessment had not been completed for the resident.

A clinically appropriate pain assessment was not completed when the resident's pain was not relieved with the prescribed routine and as needed pain medication for several weeks. The resident was at risk of experiencing ongoing pain and the failure to assess the resident's pain when not relieved by initial interventions using a clinically appropriate assessment instrument presented a risk of overlooking aspects crucial to the resident's comfort.

Sources: Resident's progress notes, care plan, Pain and Symptom – Assessment and Management Protocol policy, Medication Administration Records, and Physician Orders, and interviews with the resident, PSWs, RPNs, RN, RPN/NM, and CCC. [s. 52. (2)] (601)

2. The licensee has failed to ensure that resident #001 was assessed using a clinically appropriate assessment when the resident's pain was not relieved by the initial interventions.

The resident's SDM reported they had concerns that registered staff did not collaborate with the physician regarding the resident experiencing pain.

The resident was experiencing a specified pain for several weeks. The resident was prescribed routine and as needed pain medication. The plan of care

directed to identify factors that may aggravate or alleviate pain and to consult with the physician if the medication ordered was ineffective. Staff documentation and interviews identified the resident required breakthrough pain medication on several occasions for pain management and the as needed pain medication administered was not always effective. Registered staff interviewed identified the resident's pain was not managed and they were not aware of a Pain Assessment Tool being completed for the resident.

There was no evidence that a clinically appropriate pain assessment was completed for a specified period of time when the resident's pain was not relieved with the prescribed routine and as needed pain medication.

The resident was at risk of experiencing ongoing pain and a clinically appropriate pain assessment could have provided the resident's physician with a tool to identify, implement and monitor the medical interventions implemented to manage the resident's pain.

Sources: Pain and Symptom – Assessment and Management Protocol policy, Pain Observation Tool (POT), care plan, resident's progress notes, Medication Administration Records, and Physician Orders, interviews with PSW, RPN, RN, RPN/NM, CCC, and resident's SDM. [s. 52. (2)]

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

Severity: There was actual harm when two residents were experiencing unmanaged pain that was not relieved by initial interventions and a clinically appropriate pain assessment was not completed as there was no detailed pain assessment to provide the resident's physician when determining how to manage the residents pain.

Scope: The scope of this non-compliance was a pattern as two out of three residents were experiencing unmanaged pain.

Compliance History: One previous Voluntary Plan of Correction was issued to the home under the same subsection of the legislation within the previous 36 months. (601)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jan 31, 2022

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 : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;

(b) the identification of any risks related to nutrition care and dietary services and hydration;

(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee must be compliant with s. 68 (2) (d) of O. Reg. 79/10.

Specifically, the licensee must:

1) Develop and implement a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration. The process will identify who is responsible, and the action to be taken when residents do not meet their daily food and fluid requirements. Keep a documented record of all actions taken when a resident's nutritional needs are not met.

2) Educate the PSWs and Registered staff on the process to follow to monitor resident food and fluid intake and when an order/recommendation is received to provide a resident with additional fluids and nutritional supplements. Keep a documented record of the education provided and staff attendance.

3) Conduct weekly audits on the food and fluid monitoring process, including nutritional supplements to ensure PSWs are accurately documenting resident intake and that registered staff are acting when nutrition and hydration requirements are not met. Keep a documented record of the audits completed.

Grounds / Motifs :

1. The licensee has failed to ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

A complaint was submitted to the Ministry of Long-term Care which indicated concerns that residents were not being offered sufficient hydration.

A record review of residents #004, #008, #018 and #020 care plan identified that each resident was at risk for reduced fluid intake and was to receive additional fluids daily as per the Hydration Program. The plan of care identified for each resident that the Registered Dietitian and the Food Services Supervisor will monitor food and fluid intake. Review of the Dietary Report for food and fluids intake identified there were gaps in documentation for all four residents. The daily fluid intake totals were consistently below the identified requirements for each resident.

During separate interviews, the Acting Nutritional Care Supervisor, the Dietitian and Registered Nurses could not confirm who was responsible to review the residents nutritional intake records to identify any evaluation of the resident's or a change and decline in their fluid intake. They each confirmed that they were not doing it. The Dietitian indicated they would review the resident records quarterly but acknowledged that would be too late if the resident was experiencing dehydration.

During an interview the Director of Care (DOC) indicated the licensee's expectation is that Registered Staff would review the PSW's documentation each shift to ensure it has been completed and identify any residents who are consistently consuming less then the required food and fluid intake amounts. The DOC reviewed the intake records for resident's #004, #008, #018 and #020 and confirmed that the documentation consistently identified that the residents were not consuming the required fluids but there was also inconsistent documentation including gaps so it was difficult to get a true sense of intake. The DOC indicated that if registered staff had concerns, they could always refer to the Dietitian at any time.

Residents were at risk of dehydration when the licensee failed to ensure there was a system in place to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Sources: Observations, care plans and dietary intake records, interview with staff, Hydration Program policy. [s. 68. (2) (d)]

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

Severity: There was risk of residents becoming dehydrated when a system was not in place to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Scope: The scope of this non-compliance was widespread as four out four residents did not have a system in place to monitor and evaluate the food and fluid intake.

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

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (623)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 19, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Order / Ordre :

The licensee must be compliant with s. 71 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct daily audits for two weeks to ensure that resident #004, #008, #018, #020's planned menu items are offered and available at each meal and snack. Keep a documented record of the audits completed

Grounds / Motifs :

1. The licensee has failed to ensure that planned menu items were offered and available at each meal and snack.

A complaint was brought forward to the Ministry of Long-Term Care that residents were not being offered sufficient fluids.

Resident #004, #008, #018, and #020's nutrition care plan indicated that the residents were to be offered a specified amount of fluid at each meal and snack plus an additional amount of fluid per day outside of their meals and snacks. Resident #004, #008, #018, and #020's meal was observed on two specified dates, and the residents were not offered fluids according to their nutritional care plan. Review of the resident's total documented daily fluid intake for the specified dates identified that the residents' daily fluid needs according to their nutrition care plan had not been met.

Resident #018 was observed to be offered a nutritional supplement during their lunch meal on two specified dates. PSW #118 and PSW #137 confirmed that the nutritional supplement was from the morning and afternoon snack cart which had not been provided to the resident at their scheduled snack.

The residents were to be provided a specific amount of fluids outside of their meals and snacks and there was no evidence to support that the residents received the required fluid.

The planned menu for beverages/fluids was not offered to residents #004, #008, #018, and #020 when observed on two specified dates. This may have contributed to the residents not consuming their estimated fluid needs for the day.

Sources: Mealtime observations, resident care plan and dietary intake records, staff interviews, Hydration Program policy, facility menu plan. [s. 71. (4)]

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

Severity: There was risk of harm due to the residents may not meet their estimated fluids for the day when the residents did not receive their planned beverages at each meal.

Scope: The scope of this non-compliance was widespread as four out of four residents did not receive their planned beverages at each meal and snack.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (623)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 19, 2021

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 : 008

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

Pursuant to / Aux termes de :

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

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

Order / Ordre :

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

The licensee must be compliant with s. 73. (1) 10 of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct daily audits of meal services for a period of two weeks to ensure safe positioning of residents #004, #008, #018, and #020 and all residents during meals. If unsafe positioning is noted, provide immediate redirection and re-education. Keep a documented record of the audits completed.

Grounds / Motifs :

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

1. The licensee has failed to ensure that proper techniques were used to assist a resident with eating, including safe positioning of residents who require assistance.

A meal time observation was conducted on two specified dates, which identified residents #004, #008, 018, and #020 were not seated in a safe position for eating and drinking purposes, while being assisted to eat their meal. Record review of each of the resident's written plan of care indicated they were each at risk when not seated safely. During separate interviews, a PSW, RCA and RN indicated that residents #004, #008, 018 and #020 should have been seated in a safe position during food and fluid intake.

Resident’s #004, #008, #018 and #020 were at risk of a negative outcome when they were not positioned safely when eating.

Sources: Observations, resident care plans, staff interviews. [s. 73. (1) 10.]

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

Severity: There was risk of harm due to four residents were at risk of choking or aspiration when they were not positioned safely when eating.

Scope: The scope of this non-compliance was widespread as four out of four residents were not positioned safely during meals.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (623)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 25, 2021

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 : 009

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 229. (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure care caddies are always fully stocked and contain the necessary Personal Protective Equipment (PPE) so that supplies are always available to staff when entering a resident's room that requires additional precautions.

2. Audit staff compliance to the proper technique for donning and doffing of PPE and Hand Hygiene (HH) daily every shift until all staff have been audited and can demonstrate proper technique consistently. Keep a documented record of all staff that were audited.

3. Analyze the results of the audits and provide further education to any staff who did not adhere to the proper technique for donning and doffing of PPE and HH. Keep a documented record of the staff that required further education and continue audits for the staff identified until the staff member has achieved compliance.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program (IPAC) related to staff adherence to safely apply and remove Personal Protective Equipment (PPE), and hand hygiene (HH).

The signage outside of resident #022's room indicated the resident required contact and droplet precautions and there was no eye protection located in the isolation cart outside of the resident's room. PSW #148 did not perform hand

hygiene prior to applying the gloves and gown or apply eye protection prior to entering the resident's room. The PSW assisted the resident with care and reported that eye protection was not required as the resident was on contact precautions. Inspector #601 discussed the signage indicating the requirement for eye protection and a second staff member brought the eye protection. The CCC confirmed that resident #022 was on contact and droplet precautions and staff should have applied eye protection prior to entering the resident's room.

Observations of staff during the inspection by Inspector #601 and Inspector #623 identified staff were not always assisting residents with HH before and after meals. Staff did not always perform HH before and after providing resident direct care. Staff interviewed confirmed they had received education and residents should receive assistance with HH before and after meals, and staff should perform HH before and after providing resident direct care. The CCC indicated that all staff received education on "Just Clean Your Hands - Your 4 Moments for Hand Hygiene" program. The CCC also indicated an auditing process was in place for evaluating staff compliance with HH. Review of the Just Clean Your Hands Program "Your 4 moments for Hand Hygiene" required staff to assist residents to perform HH before and after meals and snack. Staff were also required to complete hand hygiene before initial resident and after resident environment contact.

Multiple beverages were observed at the nursing station and staff were observed to be eating and drinking in resident common areas. A PSW was observed to have a water bottle at the nurse's station, they removed their mask by placing under their chin and took a drink, no hand hygiene was performed prior to touching their mask.

The residents were at actual risk for transmission of infection when staff failed to properly apply the PPE and ensure that staff consistently performed HH when performing direct care and offer residents HH before and after meals.

Sources: Observation of staff IPAC practices, Best Practices for Hand Hygiene in all Health Care Settings, 4th edition, April 2014, Public Health Ontario (PHO) - Universal Mask Use in Health Care Settings and Retirement Homes, February 10, 2021, interviews with PSWs, RPNs, RNs, HSKs, and the CCC. [s. 229. (4)]

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

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

Severity: There was actual risk of harm to the residents because there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program. Specifically, a resident care caddy was not fully stocked with the required PPE, a staff did not adhere to the proper sequence of applying PPE, and hand hygiene practices.

Scope: The scope of this non-compliance was widespread as one staff failed to adhere to safely apply Personal Protective Equipment (PPE) and the PPE was not located in one isolation cart. Hand hygiene (HH) was not performed by several staff before and after resident contact on all three floors in the home and the HH deficiencies noted would affect all residents in the Home.

Compliance History: One previous Voluntary Plan of Correction was issued to the home under the same subsection of the legislation within the previous 36 months. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 25, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 010

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must be compliant with s. 229 (5) of O. Reg. 79/10.

Specifically, the licensee must:

1) Develop and implement a process for monitoring residents with symptoms indicating the presence of infection and include where the symptoms of infection will be documented on every shift. The process will identify who is responsible to assess the resident, and the immediate action to be taken when a resident has a symptom indicating the presence of infection. Keep a documented record of all actions taken when a resident symptom indicates the presence of infection.

2) Educate the PSWs and Registered staff on the process to follow to monitor resident's with symptoms of infection and what needs to be monitored when an order/recommendation is received by the physician to treat the resident's infection. Keep a documented record of the education provided and staff attendance.

3) Conduct weekly audits on the monitoring process of residents with symptoms indicating the presence of infection, including accurately documenting the resident's symptoms of infection on every shift. Keep a documented record of the audits completed.

Grounds / Motifs :

1. The licensee has failed to ensure that staff recorded resident #013's

symptoms of infection on every shift and that immediate action was taken when required.

The resident's physician prescribed an antibiotic to be administered daily as a preventative measure to treat an infection. There was no evidence there was any follow up regarding the resident's symptoms of infections and there was no system in place to ensure staff recorded the resident's symptoms of infection on every shift. The resident's progress notes on two specified dates indicated the resident was experiencing signs of an infection. Staff acknowledged they did not record symptoms of infection on every shift and were not aware of the requirement to record symptoms when a resident had an infection. There was also no evidence that immediate action was taken when the resident was experiencing symptoms of an infection, on two specified dates. The resident was at risk for discomfort and complications when the resident's infections were not assessed on every shift to determine if the antibiotic treatment was required or effective with treating the resident's health status.

Sources: The resident's care plan, progress notes, lab reports for 2021, Medication Administration Record, physician orders, interviews with PSWs, RN, CCC, and the DOC. [s. 229. (5) (b)] (601)

2. The licensee has failed to ensure that staff recorded resident #016's symptoms of infection on every shift and that immediate action was taken when required.

Non-compliance was identified with r. 229. (5) (b) related to resident #001 and the sample size was expanded to include resident #016.

The resident's progress notes identified the resident had impaired skin integrity on specified dates several weeks earlier and for several days prior to the physician prescribing a medicated cream for a specified number of days to treat the resident's skin infection. The documentation indicated the resident had impaired skin integrity after the completion of the medicated cream. There was also no evidence that immediate action was taken on the specified date when the resident experienced symptoms of an infection nor that the symptoms were evaluated to determine if the medicated cream prescribed for a specified number of days was effective. The resident experienced symptoms of an infection

following the treatment and there was no evidence follow up action was taken. The resident was at risk for discomfort when the resident's infection was not assessed, and symptoms were not recorded on every shift to determine if the medicated cream was effective in treating the resident's impaired skin integrity. Staff acknowledged they did not record symptoms of infection on every shift and were not aware of the requirement to record symptoms when a resident had an infection.

The resident's progress notes identified the resident had symptoms of a different infection as the resident reported symptoms of an infection. Resident #016's physician prescribed an antibiotic to treat the infection for a specified period of time. Staff indicated the resident had a history of infections and the resident was able to communicate to staff when they were experiencing symptoms. The resident was at risk for discomfort and complications when the resident's infection was not assessed, and symptoms were not recorded on every shift to determine if the antibiotic was effective with treating the resident's infection. Staff acknowledged they did not record symptoms of infection on every shift and were not aware of the requirement to record symptoms when a resident had an infection.

Sources: The resident care plan, progress notes, Head to Toe Skin Bath Assessments, lab reports for 2021, Medication Administration Record, physician orders, interviews with PSWs, RPNs, RN #157, and CCC. [s. 229. (5) (b)] (601)

3. The licensee has failed to ensure that staff recorded resident #029's symptoms of infection on every shift and that immediate action was taken when required.

Non-compliance was identified with r. 229. (5) (b) related to resident #001 and the sample size was expanded to include resident #029.

The resident's progress notes indicated the resident had a decline in condition and symptoms of infection for a week prior to the physician prescribing an antibiotic for specified period of time. CCC #102 confirmed that the resident had an infection. Staff acknowledged they did not record symptoms of infection on every shift and were not aware of the requirement to record symptoms when a resident had an infection.

The resident was at risk for discomfort when immediate action was not taken to assess the resident's change in condition and potential complications when the resident's infection was not assessed, and symptoms were not recorded on every shift to determine if the antibiotic was effective with treating the resident's infection.

Sources: The resident's care plan, progress notes, Medication Administration Record, and interview with CCC #102. [s. 229. (5) (b)] (601)

4. The licensee has failed to ensure that staff recorded resident #001's symptoms of infection on every shift and that immediate action was taken when required.

A complaint was submitted to the Ministry of Long-term Care which indicated concerns that the resident was not receiving continence care according to their plan of care and their infections were not being managed.

The resident's SDM suspected the resident had an infection for a specific month and requested a lab test be completed on two specified dates. The physician ordered the lab test on three different dates and the specimen was collected and sent to the lab a week after the physician ordered the lab test.

The resident was prescribed antibiotics during the specific month for a specified period of time. There was no further documentation to indicate that the resident's infection was assessed on every shift. Registered staff interviewed indicated they did not routinely record symptoms or assess the resident for symptoms of infection, on every shift while the resident was prescribed an antibiotic. They further indicated they would document in the resident's progress notes if a PSW reported and signs or symptoms.

The resident was at risk for discomfort and complications when immediate action was not taken and the resident's infections were not assessed on every shift to determine if the antibiotic treatment was effective with treating the resident's infection status.

Sources: Life lab reports, physician orders, Medication Administration Records,

progress notes, Interviews PSWs, RPNs and the resident SDM. [s. 229. (5) (b)]

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

Severity: There was a risk of harm when the residents' infections were not assessed, and symptoms were not recorded on every shift to determine if the physician's prescribed treatments were effective with treating the residents' infections.

Scope: The scope of this non-compliance was widespread as four out of four residents' infections did not have their symptoms recorded on every shift and immediate action was not taken.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 19, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 011

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

1. All interventions included in resident #012, #013, #014, #016, #017, #018, #021, #026 and #028's, plan of care related to continence care are implemented by all direct care staff as outlined in the plan of care.

2. Educate all staff who provide direct care to residents to ensure staff are aware of the resident's continence care schedules and that the continence schedules are implemented to promote and manage bowel and bladder continence based on the assessment. Include each disciplines roles and responsibilities related to how to ensure that staff communicate from shift to shift to ensure that the residents have received continence care according to their plan of care. Keep a documented record of the education provided and staff attendance.

3. Perform daily audits of continence care being provided to resident #012, #013, #014, #016, #017, #018, #021, #026 and #028 to ensure they are receiving continence care, as specified in the plan of care. Keep a documented record of the audits completed and continue to audit until all residents are consistently receiving continence care, as specified in the plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #001, #012, #013, #014, #016, #017, #018, #021, #026, and #028 related to continence care was provided to the residents, as specified in the plan.

Resident #001's plan of care related to continence care directed for the resident to receive total assistance from two staff for continence care. PSWs acknowledged continence care was delayed on the resident's specified floor when they were working with two PSWs instead of three PSWs on the days and evening shifts and they did not always have time to provide the resident's continence care as directed in the care plan. Resident #001 was at risk for altered skin integrity and urinary tract infections when continence care was not always provided to the resident, as specified in the care plan due to the resident being incontinent.

Resident #012's care plan related to continence care directed for the resident to receive total assistance from two staff for continence care. The Ministry of Long-Term Care received two complaints related to staffing shortages, care concerns with allegations of neglect due to care not being provided as directed in the resident's plan of care. The RPN reported the resident was crying when they entered the resident's room and discovered the resident had not received care from 0600 hour to 1200 hour on a specified date. Staff failed to provide the assistance required to resident #012 as continence care was not provided for six hours on a specified date and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #013's care plan related to continence care directed for the resident to receive extensive assistance from two staff for continence care. PSW #108 reported the resident had not received continence care as specified in their plan of care. The PSW reported that they were working with two modified staff who were unable to assist with resident care and transfers. They indicated they did not have time to provide the resident's care more than twice on the evening shift due to the workload and responding to several call bells. According to the PSW, the resident's incontinent product was saturated with urine and the resident was a high risk for urinary tract infections. PSW #111 reported a PSW working on the resident's specified floor had been relocated to the another location after breakfast due to staffing shortages. As a result of the staffing changes, the PSW reported the resident received continence care prior to 0700 hour and that they did not have time to provide the resident's care after breakfast or before lunch. Staff failed to provide the assistance required to resident #013 as continence care was not provided for five hours on two specified dates and this placed the

resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #014's care plan related to continence care directed for the resident to receive total assistance from two staff for continence care. PSW #108 reported the resident had not received continence care as specified in their plan of care. The PSW reported that they were working with modified staff who were unable to assist with resident care and transfers. They indicated they did not have time to provide the resident's care due to the workload and responding to several call bells. According to the PSW, the resident's incontinent product was saturated with urine and the resident had been incontinent of stool. PSW #111 reported a PSW working on the resident's specified floor had been relocated to another location after breakfast on a specified date due to staffing shortages. As a result of the staffing changes, the PSW reported the resident received continence care prior to 0700 hour and that they did not have time to provide the resident's care after breakfast or before lunch. Staff failed to provide the assistance required to resident #014 as continence care was not provided for seven hours on a specified date, and for five hours on the other specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #016's care plan related to continence care directed for the resident to receive total assistance from two staff for continence care. Resident #016 indicated they were able to request assistance to use the toilet and there were times when PSWs told them they would have to wait due to a second staff not being available to assist. The resident further indicated as a result they would be incontinent. PSWs acknowledged continence care could be delayed on the resident's specified floor when they were working with less than four PSWs on the days and evening shifts. PSWs further indicated that the resident could request assistance with toileting and there were times when the resident was incontinent due to staff not being available to assist the resident with toileting upon request. Resident #016 was at risk for altered skin integrity and urinary tract infections when toileting assistance was not always provided to the resident, as specified in the care plan due the resident being immobile and incontinent.

Resident #017's care plan related to continence care directed for the resident to

receive total assistance from two staff. A PSW reported a PSW working on the resident's specified floor had been relocated to another location after breakfast on a specified date due to staffing shortages. As a result of the staffing changes, the PSW reported the resident received continence care prior to 0700 hour and that they did not have time to provide the resident's care after breakfast or before lunch. Staff failed to provide the assistance required to resident #017 as continence care was not provided for five hours on a specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #018's care plan related to continence care directed for the resident to receive total assistance from two staff. The Ministry of Long-Term Care received a complaint related to staffing shortages and that the resident had not received continence care for ten hours. On the specified date, the PSW working on the day shift completed POC documentation at 1037 hour and the documentation indicated the resident had been toileted once on the day shift and the PSW working on the evening shift completed the documentation at 1946 hour and the documentation indicated the resident had been toileted three times on the evening shift. The DOC indicated they were aware of the allegations from the resident's SDM and the charge RN had interviewed the PSW working the evening shift on the specified date, and it was reported the resident had received continence care at 1500 hour. The resident's SDM reported they had evidence the resident's continence care was not provided for ten hours, record review and staff interviews indicated the resident had not received continence care for four and a half hours. PSWs interviewed indicated there were times when two PSWs were working on the resident's floor and they were not able to ensure the resident received continence care according to their assessed needs. Staff failed to provide the assistance required to resident #018 as continence care was provided once on the day shift on a specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #021's care plan related to continence care directed for the resident to receive limited assistance from one staff. PSWs reported that resident #021 had not received morning care due to staffing shortages on a specified date. The PSWs acknowledged there was no communication from the night shift regarding when the resident had last received continence care. The Resident Assessment

Instrument (RAI) Coordinator confirmed at 0930 hour, that resident care and meal service was behind on the resident's specified floor due to staffing shortages. Staff failed to provide the assistance required to resident #021 as continence care was not provided for four hours on the specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #026's care plan related to continence care directed for the resident to receive total assistance from two staff. PSWs reported that resident #026 had not received morning care due to staffing shortages on a specified date. The PSWs acknowledged there was no communication from the night shift regarding when the resident had last received continence care and they had started their shift at 0600 hour. The RAI Coordinator confirmed at 0930 hour, that resident care and meal service was behind on the resident's specified floor due to staffing shortages. Staff failed to provide the assistance required to resident #026 as continence care was not provided for four hours on the specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Resident #028's care plan related to continence care directed for the resident to receive total assistance from two staff. Resident #028 reported there were times when they would ring their call bell and staff did not immediately respond. Resident #028 indicated their bottom gets sore and on a specified date they had not received continence care or returned to bed after breakfast when they requested. A PSW confirmed the resident had not received continence care after breakfast and that there were staffing shortages on the specified date. A PSW reported there was a day when they had worked with three PSWs and one of the three PSWs was not familiar with the residents on the resident's floor. They further indicated resident care was behind on this day due to staffing shortages and resident #028 was angry at the staff because they didn't have time to assist the resident with continence care and assist the resident to bed for a rest. The PSW further indicated the resident would have received continence care at around 0730 hour on this day and the resident did not receive continence care after breakfast or before lunch. They reported the resident's continence care was provided in the afternoon and the resident's brief and clothing was saturated with urine. Staff failed to provide the assistance required to resident #028 when continence care was not always provided to the resident upon

request, before and after meals and when continence care was not provided after breakfast on the specified date, and this placed the resident at risk for impaired skin integrity and urinary tract infections due to the resident being incontinent.

Record review of resident #001, #012, #013, #014, #016, #017, #018, #021, #026, and #028's Point of Care (POC) documentation related to continence care and toileting did not support that the residents were consistently provided continence care as specified in their individual plan of care. PSWs acknowledged they did not always have time to provide continence care before and after meals when working with staffing shortages. PSWs interviewed indicated that on the day and evening shift four PSWs were required to work on the third floor and three PSWs were required to work on the first floor to ensure that all the residents received care according to their assessed needs. PSWs further indicated that modified staff were not always replaced, and this affected resident care as the modified staffs' ability to assist with resident care was limited and two PSWs could be responsible to provide toileting and continence care for all of the residents on the third floor. PSWs indicated they did their best to toilet the resident according to their plan of care, and when the resident requested to use the toilet but there were times when the resident's continence care would be delayed due to staffing shortages. The DOC confirmed there were staffing shortages and times on the day and evening shifts when two PSWs were assigned to work on the first floor and when three PSWs were assigned to work on the third floor. The DOC indicated they were not aware of any residents not receiving assistance with toileting or continence care and that residents should receive care as specified in the plan of care.

Sources: Resident #001, #012, #013, #014, #016, #017, #018, #021, #026, and #028's care plan, progress notes, quarterly continence assessment, POC documentation, interviews with PSWs, RPNs, and RNs, CCC, the DOC, and residents. [s. 6. (7)]

An order was made taking the following factors into account:

Severity: There was risk of harm to ten residents who were at risk for skin issues related to continence care not being provided as specified in the care plan.

Scope: This non-compliance was widespread as ten out of twelve residents were involved, and continence care was not being provided as specified in the plan of care.

Compliance History: Two previous Compliance Orders and one Voluntary Plans of Correction was issued to the home under the same subsection of the legislation within the previous 36 months. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2022

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 : 012

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

The licensee will prepare, submit, and implement a plan of compliance to ensure that the staffing plan and schedule are such that staffing levels are consistent with the needs of the residents. The plan will include but not be limited to the following elements:

-PSWs, RPNs, RNs, and agency staff schedule reflects continuity of resident care.
-staffing plan provides for a staffing mix on the first, second, and third floor that meets the residents assessed care needs when two staff are required to provide continence care every two hours or when two staff are required to provide continence care for residents upon rising, before and after meals, at bedtime, at 2300, 0130 and 0400 hour, and as required.
-all staff scheduled to provide resident care can perform assigned duties and responsibilities to meet the residents assessed care needs.
-Maintain accurate records that reflect the true staffing schedule that contains the date, shift and the location of the staff members assignments including agency staff.
-a documented record on how the residents care needs were assessed to determine the staffing levels required to meet the residents care needs.

Please submit the plan to CentralEastSAO.MOH@ontario.ca, Attention: Karyn Wood, Inspector #601 by October 4, 2021.

Grounds / Motifs :

1. The licensee has failed to ensure the staffing mix was consistent with the residents' assessed care and safety needs when ten residents did not receive continence care according to their assessed needs.

Five complaints with concerns that staffing shortages resulted in residents not receiving scheduled continence care and allegations of resident neglect was submitted to the Ministry of Long-term Care.

Multiple staff and family members reported they were concerned the residents

were not receiving proper care due to the limited amount of time and staff to provide the residents' care. Staff indicated the staffing schedule and the daily staffing sheets were not kept up to date and they did not reflect the actual staffing shortages. They further indicated that modified staff were not always replaced, and this affected resident care as the modified staffs' ability to assist with resident care was limited. Staff further reported they often worked with agency staff who were not familiar with the residents' plan of care. Staff interviewed indicated they were exhausted from the extensive workload and from working overtime due to the staffing shortages.

Please refer to the area of non-compliance identified within this report related to s. 6 (7) of the LTCHA regarding staffing shortages that were conveyed as the reason the licensee failed to provide the individualized plan of care for residents #001, #012, #013, #014, #016, #017, #018, #021, #026, and #028 to promote and manage bowel and bladder continence based on the residents' assessment and the delay in continence care resulted in the residents going a significant length of time without continence care placing the residents' at risk for impaired skin integrity and urinary tract infections.

There were 99 residents residing in the home at the time of this inspection. Review of the staffing plan identified that 102 residents required fourteen PSWs to work on the day shift, eleven PSWs to work on the evening shift and six PSWs to work on the night shift. Review of the daily staffing sheets and interview with the Director of Care (DOC) identified that attempts were being made to increase the evening staffing levels from three PSWs to four PSWs working on the third floor.

Review of the 2020 Evaluation of Staffing Plan identified that if a shift goes unfilled staff were relocated based on the resident needs for the shift. The charge nurse checks the staffing levels at the beginning of the shift and relocates the staff based on the resident needs for the day. Review of the 2021 Evaluation of Staffing Plan identified COVID-19 had affected the staffing levels due to increased staff call ins and not being able to share staff between health care facilities.

Inspector #601 reviewed the staffing schedule, daily staffing sheets and the staff entering the home based on the COVID-19 screening records from June 13 to

July 9, 2021. Inspector #601 was not able to accurately determine who had worked during this time nor the location where the staff had worked. The documentation provided by the DOC showed that there was a total of 43 out of 81 PSW shifts that were not covered as per the homes staffing plan from June 13 to July 9, 2021. There were several night shifts when there was one registered practical nurse (RPN) responsible for all the residents in the home. The DOC acknowledged the staffing schedule and daily staffing sheets provided to Inspector #601 may not reflect the actual staffing levels and the staffing levels were often below the planned staffing complement. According to the DOC, the staffing plan directs the charge nurse to review the residents care needs when there are staffing shortages and redirect staff work locations based on the resident needs. They further acknowledged that modified staff were not always replaced nor able to assist with resident care and would remain on the staffing schedule. The DOC further indicated attempts for staff recruitment was ongoing and as of July 13, 2021 there were ten to twelve PSW part-time positions that remained vacant. There was one RN part-time night line and one RPN part-time night line vacant. According to the DOC, several agency staff have been working in the home and efforts have been made to provide continuity of resident care.

The licensee has not been able to recruit and retain staff according to the home's staffing plan and there was actual risk of harm when several residents' assessed care needs according to the staffing plan was not met when the home does not have the full complement of staff working. Staffing shortages in the home puts the residents at risk due to the staff reporting they don't have enough time to provide proper care to the residents. The staff report they do their best to provide care to the residents, but they need to take short cuts putting the residents and themselves at risk for injury.

Further, the shortage of staff and its impact on residents not receiving care according to the plan of care, including continence care or delayed care demonstrates that the licensee did not ensure that residents assessed care needs were met.

Sources: Review of several residents clinical health records, Master Schedule, Daily Staffing Sheets, Staffing plan for 2020, Evaluation of Staffing Plan 2020/2021, interviews with PSWs, RCAs, RPNs, RN's, AA's, HSKs, DAs, RAI Coordinator, CCC, Admin A, LEC, and DOC. [s. 31. (3)]

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

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

Severity: There was actual risk of harm when the shortage of staff and its impact on ten residents not receiving care according to the plan of care, including continence care or delayed care demonstrates that the licensee did not ensure that residents assessed care needs were met.

Scope: The scope of this non-compliance was widespread as a total of ten residents were involved and the staffing shortages involved the entire home.

Compliance History: One previous Director Referral and two Compliance Orders were issued to the home under the same subsection of the legislation within the previous 36 months. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 19, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

Issued on this 23rd day of September, 2021

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Karyn Wood

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