Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Sep 22, 2016;	2016_250511_0006 (A1)	008291-16	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (no.1) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

WEST PARK HEALTH CENTRE
103 Pelham Road St Catharines ON L2S 1S9

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

ROBIN MACKIE (511) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Change Compliance Order due date.

Issued on this 22 day of September 2016 (A1)

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

Original report signed by the inspector.

Ontario

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ROBIN MACKIE (511) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 5, 6, 7, 8, 12, 13, 14, 15, 18, 19, 20, 21, 22 and August 11, 2016

007418-14 CIS (Hospitalization), 001824-15 CIS (Alleged abuse), 002086-15 CIS (Alleged abuse), 002700-15 CCAC (Bed refusal), 002746-15 CIS (Alleged abuse), 004340-15 CIS (Assistance with meals), 005818-15 Complaint (Resident Charges), 006706-15 CIS (Medication Incident), 010608-15 CIS (Responsive Behaviors), 011379-15 Follow up 2014_322156_0003 CO#1, 011380-15 Follow up 2014_322156_0003 CO#002, 011381-15 Follow up 2014_322156_0003 CO#003, 015839-15 CIS (Responsive Behaviors), 026234-15 CIS (Responsive Behaviors), 030412-15 CIS (Missing Narcotic), 35642-15 CIS (Missing resident), 000072-16 CIS (Responsive Behaviors), 003629-16 CIS (Alleged Abuse), 000149-14 CIS, 003906-15 CIS (Alleged Neglect), 008091-15 CIS (Responsive Behaviors).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Dietary Manager, Recreation Manager, Office Manager, RAI Coordinator, Registered Dietitian registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, dietary staff, family members and residents.

During the course of the inspection the Inspectors observed the provision of resident care, meal service, reviewed applicable policies, practices and resident clinical records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Admission and Discharge

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

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

20 WN(s)
9 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 221. (2)	CO #003	2015_322156_0003	611
O.Reg 79/10 s. 50. (2)	CO #001	2015_322156_0003	510a
O.Reg 79/10 s. 8. (1)	CO #002	2015_322156_0003	510a

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Findings/Faits saillants :

1. The licensee failed to protect all resident from abuse.

1) A review of a critical incident, reported by the home, identified that on a specific day in 2015 resident #609 was witnessed to demonstrate a responsive behaviour to resident #608, which caused resident #608 to fall to the floor and sustain an injury. Resident #608 was sent to hospital for an assessment. The progress notes documented on the day of the incident indicated resident #608 sustained a

physical injury as a result of the altercation.
During a review of resident #609's progress notes it was identified that there were no documented notes for resident #609 during a three week time frame surrounding the incident. In an interview with the Director of Care (DOC) on April 22, 2016, it was confirmed that resident #609's physical responsive behaviour, demonstrated at the time of the incident, was not documented. It was also confirmed that actions taken to respond to resident #609's demonstrated responsive behaviour, including reassessments and interventions and resident #609's responses to the interventions, were not documented.
A review of resident #609's progress notes, documented the month before the identified specific incident, identified they had a previous altercation with another resident, when the other resident tried to enter resident #609's room. A review of resident #609's progress notes, documented the month after the incident, identified that resident #609 had another physical altercation which resulted in a resident's fall to the floor, when the resident entered resident #609's room.
A review of resident #608's plan of care identified they had known verbal and physical responsive behaviours and frequently wandered the halls and into other residents' rooms. Resident #608 previously sustained an injury two months before the specified incident, when they wandered into resident #602's room and an altercation occurred which caused resident #608 to fall to the floor.
A review of resident #609's plan of care identified the plan was not revised to identify the physically responsive behaviours until approximately one month and a half following the initial incident. In an interview with the RAI co-ordinator it was confirmed that resident #609's quarterly review assessment, completed approximately four months later, did not identify resident #609's physical responsive behaviours. In an interview with the DOC on April 22, 2016, it was confirmed that resident #609 had not been referred to, or followed by, Behavioural Supports Ontario (BSO) at the time of their demonstrated physical responsive behaviours.

2) A review of a critical incident and the progress notes documented on a day in 2015, identified that resident #609 was observed to have a physical altercation with resident #040 during a meal service.

An interview with registered nursing staff, who was present at the time of the incident, was completed on April 20, 2016. It was identified that resident #040 and resident #609 had sat beside each other at the same table in the dining room. Resident #609 was observed to become verbally responsive towards resident #040. The verbal responsive behaviours between resident #609 and #040

escalated into a physical altercation. Resident #609 removed them self from the dining room after the incident.

The documented progress notes and critical incident report indicated the first staff interventions were noted to take place after resident #609 left the meal service.

Resident #040 was assessed to have an injury that required treatment by the Long Term Care physician. The resident was monitored and the physician recommended that resident #040 be transferred to hospital but the resident declined.

Prior to this incident resident #609 was known to have demonstrated verbal and physical responsive behaviours which caused injuries to other residents and resident #040 had known verbal responsive behaviours. A review of resident #609's care plan identified the plan was not reviewed or revised after the incident, which was confirmed in an interview with the DOC on April 22, 2016.
In an interview with registered nursing staff #119, on April 20, 2016, it was shared that resident #040 and #609 remained at the same dining table after the incident.
In a progress note documented by the Dietary Manager it was identified that resident #609 had requested to be moved to a new table.

A review of the BSO notes documented in 2015 identified the BSO had followed resident #040 in relation to strategies for being resistive to care and verbally responsive to staff. In an interview with the DOC, on April 22, 2016, it was confirmed that the BSO had not provided interventions on how to manage resident #040's verbal responsive behaviors. It was confirmed that the incident between resident #040 and #609 had not been communicated to the BSO when they had spoken to registered staff in relation to resident #040 demonstrated responsive behaviours.
In an interview with the DOC it was confirmed that resident #609 had not been referred to, or followed by BSO, at the time of their demonstrated physical responsive behaviours.
The education attendance records for responsive behaviors and gentle persuasive approaches were reviewed for 2015. It was identified 42 out of 80 direct care staff had not received training. In an interview with staff #126, on April 21, 2016, it was confirmed that all staff that provided direct care to residents had not been trained on mental health issues, including caring for persons with dementia and behavior management. (#583) [s. 19.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: 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. (1) This section and sections 32 to 47 apply to,
(a) the organized program of nursing services required under clause 8 (1) (a) of the Act; and O. Reg. 79/10, s. 31 (1).
(b) the organized program of personal support services required under clause 8 (1) (b) of the Act. O. Reg. 79/10, s. 31 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for (a) a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this regulation.

A) Resident #202's plan of care indicated the resident required one staff assistance with their meals. The resident had an inability to eat meals by themselves. On a day in 2016, at a meal service, the resident received a modified textured meal that was placed in front of them. Staff #100 was noted to feed another resident at the table while resident #202 sat with their meal in front of them for 20 minutes without being assisted. Staff member #100 indicated the licensee had recently reduced the front line, PSW, staffing support on the evening shift by eliminating a 1630-

2030 hours position and a 1400-2000 hours position. The staff member indicated they were unable to meet the feeding needs of the residents due to staffing changes.

B) Resident #035 was observed to have their therapeutic textured meal placed in front of them on a date in 2016 during a meal service. The resident was identified in their most recent nutritional assessment as being at a nutritional risk and had a potential for an inability to eat independently. Staff #102 was observed to feed two other residents at the same table while resident #035 sat for 45 minutes and did not touch their meal. Staff #102 left the table to complete other registered nursing care related tasks. Staff member #100, after feeding two other residents at a different table, came and sat beside resident #035 and fed the resident three quarters of their meal. Interview with PSW #100 confirmed resident #035 required assistance with eating and did not have a staff member available to assist them for 45 minutes. Interview with staff #102 confirmed they were unable to consistently feed residents that required assistance when registered nursing tasks required them to leave the dining room. Staff #102 confirmed they were the only registered nurse responsible for the residents of the home when they worked on the specified date in 2016. Interview with the DOC confirmed the registered nursing tasks, if required by staff #102 during the dining service, would supersede feeding residents.

C) During a meal service in 2016 three PSWs were noted to be sitting with residents that required assistance with feeding them their desserts, in one area of the dining room while the other side of the dining room remained unsupervised with greater than 10 residents that still had a portion of their meal in front of them. Interview with the three PSWs confirmed they were required to assist feeding the residents their desserts and there were no staff members available to supervise the other section of the dining room, that was out of view of the three staff members, for greater than 10 minutes.

D) During the initial lunch service on a day in 2016 it was observed that the Food Service Supervisor fed two residents their lunch meal. The Administrator was also observed to enter and leave the dining service and occasionally served meals to residents from the servery. Interview with the Food Service Supervisor confirmed they did not provide this assistance seven days a week/three meals per day, were not part of the daily front line staffing schedule and would help out only when they were able, in order to provide assistance with feeding, as needed . The Administrator confirmed management staff did not provide meal service assistance

as part of the routine meal service 24/7 days a week.

E) During observation of two separate lunch observations and one dinner meal service, during the RQI in 2016, the Inspector observed two different PSWs add thickener to the fluids of resident #201 and #202, whom required therapeutic textured fluids according to their most recent plans of care. A review of the clinical record indicated resident #201 and #202 had been identified as a nutritional risk. The staff members were observed adding one and two scoops to the fluids with a spoon, stirred the fluid and immediately proceeded to administer the fluids. Resident #202 initially coughed and the staff member stopped pouring it in the resident's mouth and stated " this is too thin" and proceeded to add two more rounded spoonfuls to the fluid. Both residents received fluids that were too thin as the thickener did not thicken in the time between when they added it to the fluid and when they gave it to the resident, which was approximately 30 seconds to one minute. The staff stated they used the utensils that were available on the table and would use anywhere between one heaping spoonful to up to four to thicken the resident fluids.
The staff members were observed to not accurately measure the amount of the thickener or wait the required time, as per the thickener instructions prior to feeding the resident. The fluids were not provided as per the physician ordered consistency of thickened fluids at these meal services. The recipe and directions for the thickening product instructed the staff to measure the liquids and the dry product thickener before thickening and to use level dry measuring utensils for the thickener. The liquid was to be stirred 'briskly' with a fork or a wire whisk and to allow three to five minutes for liquid to reach the desired consistency. Milk was advised that it could take up to 30 minutes for the desired consistency to be reached. Interview with both PSWs indicated they were unaware of the time frames required to allow the fluids to thicken and indicated they did not have the time to obtain the proper measuring utensils, measure and wait 5 to 30 minutes for the fluids to thicken prior to assisting residents to drink their fluids at the point of service.

F)
a. During an interview for resident #019 the SDM indicated their family member required staff to assist the resident with toileting and often had to wait over 30 minutes for staff to assist the resident. Family reported the resident had incontinent episodes while waiting for staff assistance.
b. During a resident interview for resident #026 they stated there used to be more staff to assist them when they rang the bell to be toileted and now, by the time the

staff arrived, it was 'too late' and they would have been incontinent. They stated they were no longer toileted by a method of their choice.
Interview with staff number #116, confirmed that resident #019 and #026 both had been identified by the home to require staff assistance for toileting. Staff #116 confirmed there were no physical reasons that either of these residents could not be toileted by a method of their choice with staff assistance. Interview with staff #117 indicated both residents would be safe to toilet by a method of their choice and there would be no physical safety risk to prevent toileting by staff. Staff #116 confirmed the staff would not have the time to toilet, using the residents method of choice, as required by the residents.

G) During the 2016 RQI observation, approximately an hour after a meal service, resident #024 was observed sitting in their wheelchair, beside their bed with the lights off. The resident was quiet with their eyes closed and did not appear to be distressed. A review of their clinical record indicated the resident had risk factors for skin to breakdown that included a history of incontinence, mobility deficit, inability to reposition them self and a severe cognitive deficit. The clinical record indicated they had an identified alteration in their skin integrity at the time of the observation. Interview with PSW #112 and #115 confirmed the resident had been sitting at their bedside since the meal service and stated they were to return them to their bed immediately after meal service as they were to be only up for specified time periods. The two PSWs stated they had not assisted the resident to return to bed as required in the plan of care as they had a number of residents that required a two person lift. The staff members confirmed they were unable to provide resident #024 their care, that was consistent with the resident's assessed care and safety needs, until they finished the other residents more than one hour after the resident had consumed their meal. They stated that the PSW breaks started and they would be unable to provide this resident assistance until other staff returned to the floor as there would be no other PSW available on the floor to assist with other resident care needs. The PSWs stated they were frustrated as they felt they were having difficulty meeting the increasing resident needs and had a hard time meeting the current needs of the residents with the recent decrease in staffing.

H) During the RQI in 2016 resident #030 was observed to be sitting in front of the shower room in a hospital gown that had food stains and crumbs on their front for approximately 35 minutes. Interview with staff #115 indicated it was the resident's shower day and that they had placed the resident there to wait for their shower. Staff #115 stated they had planned to provide the resident their shower when the resident was placed by the shower room door. The shower room was empty during

this time and the staff member indicated they had not had the time to start the resident's shower as they had been running behind from the meal service and the staff breaks had started. They confirmed they would be unable to provide the resident their shower until other staff members came back approximately two hours later.

I) In an interview with resident #600's Substitute Decision Maker (SDM), during the RQI in 2016, it was shared that resident #600 was not bathed as per their preference on a specific date in 2016. The SDM stated they were told the unit was short Personal Support Workers and that when this occurred residents would receive bed baths. A review of the plan of care identified that resident #600 preferred to have a shower. In an interview with staff #113 and #114, on a day during the RQI in 2016, it was confirmed resident #600 received a sponge bath and was not bathed as per their preference.

The day shift bath schedule, for a date during in 2016, was reviewed and the bathing preferences for the residents scheduled to be bathed were reviewed in the plan of care. It was identified resident #603, #025, #605, #606, #036 and #607 preferred a tub bath and resident #604 and #029 preferred a shower. In an interview with staff #113 and #114 it was confirmed that the residents had full body sponge baths and were not bathed by a method of their preference as they did not have the time.
A memo dated in 2016, identified the home would not be replacing shifts. In an interview with staff #124 it was confirmed that the regular PSW complement on the specified date was four staff on day shift and one staff was unable to come in and they were not replaced per the direction of the home. (583)

Interview with staff # 100, #102, #116, #117, #112 and #115 indicated they were unaware of a new staffing plan that would direct them on how to continue to meet care needs when the staffing reductions had occurred.

Interview with the Administrator confirmed the licensee had decreased front line staffing by 217 hours biweekly that commenced March 2016. These hours consisted of one fulltime PSW and their relief staff, from second floor evening shift 1400-2000 hours, and two 1630-2030 hours from each floor. The day shift, second floor, was further reduced on March 30th by seven hours (70 hours biweekly) when they moved a PSW team member who had been working a 0600-1330 hour shift from days to nights. These hours where not replaced. This PSW duties assignment was reviewed and indicated the resident had been assigned five team members for

morning care and assisted in the dining room. The Administrator confirmed the front line staffing compliment will be further reduced by another fulltime equivalent for days on May 9, 2016, bringing the PSW staffing compliment to four full time staff members for first floor (46 residents) and second floor (45 residents) on days. On evenings the staffing will be three PSW for 46 residents on first floor and three PSWs on second floor for 45 residents on evening.
The Administrator stated the 217 hours were reduced to accommodate a previous reduction in the Case Mix Index (CMI) that went from .96 to .93. According to the Canadian Health Care Institute the Case Mix index (CMI) uses case mix methodologies to categorize residents into statistically and clinically homogeneous groups based on the collection of clinical and administrative case data by a long term care home. The CMI value is one factor used to determine the allocation of resources to care for and/or treat the residents in health care facilities. The case mix methodologies and their accompanying resource indicators are used to effectively plan, monitor and manage the services they provide. The Administrator stated the home's current CMI as of April 4, 2016 was .99 and believed that the previous reduction in CMI was based on inaccurate coding. Clarification with the Administrator and the DOC confirmed that inaccurate coding through the CMI would not necessarily reflect the current care need of the residents today.
In addition to the 217 hour decrease in front line hours there was direction from the licensee to not replace staff without prior authorization. A review of a memo from the Administrator to the staff, dated March 22, 2016, Subject line: "Drop in Funding" and "Due to the significant drop in our CMI, we will not be replacing shifts, using Agency staff or offering over time without the approval from the Administrator. A review of the document, provided by the home, titled "Rotation Health Care Aides" showed the shifts and hours that staff were not replaced from the period of March 21, 2016 to April 17, 2016. The following staffing details for the hours not replaced on the floor was confirmed by staff # 124 (ward clerk/staff scheduling) and is as below:
PSW
March 21 two shifts: 15 hours, March 22 one shift: 7.5 hours, March 23 one shift : 7.5 hours, March 27 one shift: 7.5 hours, April 1 one shift: 7.5 hours, April 9 one shift: 7.5 hours, April 16 one shift: 7.5 hours and April 17 one shift: 7.5 hours
RPN
March 22 one shift: 7.5 hours, March 23 one shift: 7.5 hours, March 24 one shift: 7.5 hours
Housekeeping
April 11 one shift: 7.5 hours
Recreation Staff

March 24, 27, 31, April 1, 8, 9, 10,12 and 13, 2016: 7 hours each shift (63 hours total)

There was a total of 54 hours of PSW hours, 22.5 hours of RPN and 63 hours of recreation staff that were not replaced for the period of March 21, 2016 to April 17, 2016. This is a total of an additional 139.5 hours to the 217 reduced hours. [s. 31. (3)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out, (c) clear directions to staff and others who provided direct care to the resident. 2007, c. 8, s. 6 (1).

Under the focus of toileting for resident # 019, it was documented that the resident verbally expressed a toileting method of their choice.The identified goal in the document the home referred to as the care plan, was to toilet the resident using a specified method of their choice. Three different interventions were provided that

indicated different directions to the staff for toileting the resident. The DOC confirmed the above and confirmed that clear direction was not provided to staff and others who provide direct care to a resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that care was provided to the resident as specified in plan. The licensee failed to ensure that care was provided to the resident as specified in plan.

A review of the progress notes documented in 2016 identified resident #026 was toileted by one staff member. A review of the toileting care plan in place at this time directed two staff to toilet resident #026. In an interview with staff #123 on April 22, 2016, it was confirmed that care was not provided as specified in the plan. (#583) [s. 6. (7)]

3. The licensee failed to ensure that the resident's plan of care was revised at least every six months and at any other time when the resident's care needs changed.

A) A review of the quarterly MDS assessment completed in February 2016 identified resident #042 required extensive assistance from one staff member for feeding. In an interview with staff members assisting residents in the dining room for lunch service on the second floor on April 22, 2016, they confirmed that the level of assistance was accurate per the February 2016 assessment. A review of the care plan identified that resident #042 required limited assistance from one staff and that the intervention was last revised December, 2015. In an interview with the Director of Care on April 22, 2016, it was confirmed that the plan of care was not revised when the resident's care needs changed. (583)

B) In December 2015 resident #040 exhibited responsive behaviours during two incidences with two separate residents. The altercation occurred when resident #505 entered resident #040's room, resulting in an injury to resident #505. The second incident occurred between resident #040 and resident #038. There were no injuries as a result of this second incident.
In December 2015 resident #040 was reassessed and was provided a staffing intervention as a result of the incidences that occurred in December 2015. This intervention was again reassessed and the staffing intervention was discontinued in 2015.
The current care plan for this resident continued to indicate that the staffing intervention was still in place for resident #040 until further notice. An interview conducted with staff #123 confirmed that this intervention was no longer in place

for this resident, and the home failed to update the documentation to support this change.
An interview with the Director of Care (DOC) confirmed that this intervention was no longer in place for this resident and the home had not revised the plan of care when the resident's care needs changed. (611) [s. 6. (10) (b)]

4. The licensee failed to ensure that the resident's plan of care was revised when the care set out in the plan of care had not been effective.

A review of the plan of care for resident #608 identified they were assessed to have verbal and physical responsive behaviours. A review of the critical incident submitted by the home and the progress notes, completed on an identified day in 2015, identified resident #608 and #602 demonstrated verbal and physical responsive behaviours which resulted in an injury to resident #608 . Both residents were assessed to have cognitive impairment.

Prior to the incident, the progress notes had identified that resident #608 continued to exhibit the responsive behaviours for three days leading up to the incident. It was documented that interventions were not effective and the behaviour continued.

In an interview with the RAI co-ordinator and upon review of the plan of care it was confirmed that the behaviour care plan had not been revised when the care set out in the plan of care was found to be ineffective. In an interview with the DOC on April 22, 2016, it was confirmed that BSO discharged resident #608 in 2014 and they were not re-referred when interventions were found to be ineffective. (583) [s. 6. (10) (c)]

5. The licensee has failed to ensure that when the care set out in the plan had not been effective, that different approaches were considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Resident # 028 was admitted to the home in 2013. A Morse Falls Risk Assesement completed four months later determined the resident had been at a high risk for falls. The resident experienced falls in June 2013, December 2013, and March 2014, with no injuries. Post fall assessments completed on each of these dates indicated the care plan was reviewed and no update required. In June 2014, the resident experienced their fourth fall in 12 months, which resulted in an injury. Review of the document the home referred to as the care plan, dated in June 2014, revealed a focus for falls with a goal of reducing the number of falls

and preventing injury. This focus was created May 2013 and revised January 2014. Interventions under the falls focus remained unchanged. The above was confirmed by the DOC. When care set out in the plan of care was not effective, different approaches to care were not considered. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's plan of care is revised when the care set out in the plan of care has not been effective, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #028 was assessed as being at high risk for falls. The resident experienced three falls with no injury. In June 2014, the resident experienced their fourth fall in 12 months that resulted in an injury. Review of the clinical record revealed the absence of documentation related to an interdisciplinary review and assessment of the resident's falls. The DOC confirmed the home did not document assessments, reassessments, interventions and the residents response to interventions related to the falls program, for this resident. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

A review of the progress notes documented in March 2016 and the incident note dated in the same month identified resident #026 was toileted by one staff member. The resident stood independently when finished then started to slip at which time the staff member assisted them by lowering the resident to floor. A review of the plan of care in place at the time of the incident identified resident #026 required extensive assistance from two staff for toileting.

In an interview with staff #123 on April 22, 2016, it was confirmed that the incident report documentation identified staff did not use safe transferring technique as the resident was transferred with one staff present. Staff #123 shared this was not a safe positioning technique for resident #023 who was at a risk for falls. (#583) [s. 36.]

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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home developed protocols for the referral of residents with responsive behaviours to specialized resources where required.

A review of resident #608's plan of care identified they were discharged from Behavioural Supports Ontario (BSO) in June 2014, and they had not been re-referred. The plan of care identified resident #608 continued to demonstrate responsive behaviors. In April 2015 and June 2016, resident #608 exhibited responsive behaviours which resulted in an injury to resident #608. In an interview with the DOC in April 2016, it was confirmed that BSO discharged resident #608 in June 2014, and they were not re-referred when the interventions were found to be ineffective.

A review of the progress notes identified the resident demonstrated physical responsive behaviors in June 2015 and September 2015, which resulted in injuries to residents. A review of the BSO for resident #609 identified they were not referred to the Geriatric Mental Health Outreach program until December 2015 and BSO's initial assessment was dated December 2015. In an interview with the DOC on April 22, 2016, it was confirmed that there was no other documentation from external programs for resident #609.

During a review of the home Responsive Behaviour Policy (09-05-01), September 2010, and an interview with the DOC on April 22, 2016, it was confirmed that the home did not have a protocol to determine when residents should be initially referred or re-referred to BSO. (583) [s. 53. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home developed protocols for the referral of residents with responsive behaviours to specialized resources where required, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

During this inspection, the minutes from the Residents' Council meetings were reviewed for the period of February 2015 to January 2016. In addition, all Resident's Council issues/concerns forms were reviewed.

During this identified period of time, there were twelve (12) incidences where a written response was not provided under the "Summary of Investigation, action plan with time frames" portion of the document used by the home to provide responses to Residents' Council. In addition, there were two incidences where a date was not provided with the response on the document. As a result, there was no evidence to support the response was provided in writing within ten days of receipt of the concern or recommendation.

Upon further review of the Residents' Council minutes there were twenty-two incidences where a written response was provided in excess of ten days. These late responses varied from twelve days to twenty-five days.

The above noted information was confirmed through an interview with Recreation Manager. This information was further reviewed with the home's Administrator. [s. 57. (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 they respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in 2) mental health issues, including caring for persons with dementia, behavior management and 6) any other areas provided for in the regulations at times or at intervals provided for in the regulations.

A review of the education attendance records for responsive behaviors and gentle persuasive approaches were reviewed for 2015. It was identified 69 out of 87 direct care staff received training. In an interview with staff #126 it was confirmed that all staff that provided direct care to residents were not trained in mental health issues, including caring for persons with dementia and behavior management. This was confirmed with the Administrator on August 11, 2016

The education attendance records were reviewed for 2015 for pleasurable dining which content included dining/snack service legislative requirements, positioning and feeding assistance. It was identified 64 out of 80 direct care staff received training. In an interview with staff #126 and #124 it was confirmed that all staff that provided direct care care to residents were not trained in pleasurable dining. (583) [s. 76. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in mental health issues, including caring for persons with dementia, behavior management and any other areas provided for in the regulations at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including the following: 3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

A critical Incident report was submitted by the licensee in November 2015 that described seven vials of missing narcotics in October 2015. The narcotics were believed to be missing when an RN and RPN completed a shift count and one staff member insisted on visibly counting the actual stock in the narcotic bin. On inspection of the locked narcotic bin there were no vials of the narcotic. An investigation by the home took place and it was determined that the alleged missing narcotics were from the home's Emergency stat box and, at an unknown time, the medications were moved to another 'unused' location (that was double locked) and had been continued to be signed for by staff but not visibly counted. The DOC had confirmed the controlled substance had been moved, from the regular place of storage for narcotic and controlled drugs, and were signed for but not actually counted by the registered staff for an an unknown period of time. The DOC confirmed this practice had not ensured the security of the drug supply and that all narcotics and controlled drugs should have been visibly counted at the end of each shift. The Licensee had not taken steps to ensure the security of the drug supply which would have included completing a monthly audit to ensure there were no discrepancies in the narcotics and controlled substances. [s. 130. 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to ensure the security of the drug supply, including the following: 3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action will be taken if any discrepancies are discovered, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

In April 2015, resident #507 was administered an incorrect dosage of medication resulting in harm to the resident. Resident #507 had an order in place to receive a medication every four hours as needed. During the transcription process, the home's contracted pharmacy incorrectly transcribed the dosage onto the Medication Administration Record (MAR).

The medication was dispensed in ampules contained in a labelled box that matched the physician's order for the medication. In April 2015, the Registered Practical Nurse (RPN) administered the incorrect dose of the medication, and failed to notice the discrepancy between the MAR and the label on the medication. As a result, this resident did not receive medication in accordance with the directions for use as specified by the prescriber.

Shortly after the administration of the incorrect dosage of the medication, resident #507 was transferred to the hospital by ambulance. This resident returned from hospital and was noted to be in stable condition.

The Director of Care confirmed this incident occurred and further confirmed that the RPN involved in the incident was counseled as a result of the incident. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program.

A) During the RQI in 2016 RPN #110 was observed to pick up an oral medication off the floor, located under the table of the resident, and administer this medication to the resident's mouth. Interview with the RPN confirmed the medication had fallen on the floor and should not have been administered to the resident. Interview with the DOC confirmed administering medication that had been on the floor, to a resident, would not be part of the Infection Prevention and Control program.

B) On April 4th and 5th during an observation of the meal service two separate PSW's were observed to use a resident's teaspoon to obtain thickener from the bulk thickener container that was in the middle of the resident's table. The resident's drink was stirred and when it did not appear to be thick enough the staff reused the same spoon multiple times to add thickener. Interview with the DOC confirmed that multiple accessing of the bulk thickener, with the same spoon, would not be part of the Infection Prevention and Control program [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident in the home was bathed, at a minimum, twice a week by a method of their choice that included tub baths, showers and full body sponge baths.

In an interview with resident #600's Substitute Decision Maker it was shared resident #600 was not bathed as per their preference. A review of the plan of care identified that resident #600 preferred to have a shower. In an interview with staff #113 and #114, on April 14, 2016, it was confirmed resident #600 received a sponge bath and was not bathed as per their preference.

The day shift bath schedule for a specific date in 2016 was reviewed and the bathing preferences for the resident's scheduled to be bathed were reviewed in the plan of care. It was identified resident #603, #025, #605, #606, #036 and #607 preferred a tub bath and resident #604 and #029 preferred a shower. In an interview with staff #113 and #114 it was confirmed that the residents had full body sponge baths and were not bathed by a method of their preference. (583) [s. 33. (1)]

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee failed to review the placement co-ordinator's copies of the assessments and information that were required to have been taken into account, under subsection 43 (6) for consideration, and approve the applicant's admission to the home unless, (a) the home lacked the physical facilities necessary to meet the applicant's care requirements.

An applicant had applied to the Long Term Care home as identified on the CCAC application form dated December 2014.
A review of the Community Care Access Centre (CCAC) Long Term Care home Wait List response form, dated January 2015, had indicated the home refused the resident due to the " Long Term Care Home (LTCH) lacking the physical environment necessary to meet care requirements".
A letter, dated in January 2015, from West Park Long Term Care indicated that due to safety concerns that had been brought forward on the CCAC assessments the home was unable to accommodate their request for admission.

Interview with the Administrator and the DOC confirmed the home had concerns with previous residents similar behaviours and they had declined the admission without having fully reviewed the placement co-ordinator's assessments and information that were required to have been taken into account, under subsection 43 (6) for consideration and approval for the applicant's admission to the home. [s. 44. (7) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).
(e) continence care products are not used as an alternative to providing assistance to a person to toilet; O. Reg. 79/10, s. 51 (2).
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

The Minimum Data Set (MDS) Continence Assessment, dated in February 2016, reported that resident #019 had been incontinent daily but there was some control present. The document the home referred to as the care plan identified that the goal for care was for the staff to support the resident to increase functional ability and dignity to use the toilet. Review of the clinical record revealed the absence of any continence assessments to identify causal factors, patterns, type of incontinence or potential to restore function for resident #019. The DOC confirmed the above and that it was the home's expectation that continence assessments would be completed at least quarterly. The resident who was incontinent did not receive a continence assessment using a clinically appropriate assessment instrument. [s. 51. (2)]

2. Every licensee of a long-term care home shall ensure that, (f) there were a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

During stage one of the Resident Quality Inspection (RQI), resident #026 stated they required the use of 'extra' incontinence products and stated the staff only had access to three or four products a day and this made them feel unclean when they felt their product could not be changed when needed.

Interview with three PSWs (#115, #113, #112), who had provided care to the resident, confirmed when this resident and other residents were incontinent they referred to the Resident Profile Worksheet, dated April 2016, to see the allotted briefs for each resident for each shift. A review of this worksheet, dated April 2016, indicated resident #026 had been allotted two large incontinent products for days and evening. The three PSWs each identified that extra briefs were locked in a closet on the second floor and were obtainable through the RPN. The staff stated that, although they could obtain extra products, it often took a 'long' time to get

them and that the products were not available and accessible at the time they needed them.

On observation, by Inspector #511, a request for an extra brief was made to RPN #118. The RPN indicated the incontinent products were locked in a storage closet and they would have to get a key from the RN. The RPN was observed to provide medication and treatment to another resident and stated they would contact the RN when they had completed this task. The RPN was observed to complete this task and proceeded to call the RN. The phone line was busy and the RPN walked to another floor to notify the RN of the need for the extra product. When the RPN returned to the floor they indicated to the Inspector that the RN was 'busy' but would be up to the floor shortly to obtain the additional incontinent product. The RN arrived on the floor, with the key, and proceeded to the medication room. A basket of incontinent products were observed in the medication room and the RN confirmed these products were for the next shift only. The RN indicated that occasionally extra products would be on the counter, located in the medication rooms, but were not available at this time and that they would have to obtain the 'extra' product from the locked storage closet. Observation of the medication rooms, on both floor one and floor two, did not reveal that extra products were available and accessible in the medication rooms. On observation by Inspector #511 it took greater than 21 minutes from the initial request for the incontinent product to the time a product was obtained. The RN confirmed that, when they were busy with nursing care, the PSW staff would have to wait to obtain the incontinent product until they were available as they were the only staff that had the key to the locked storage closet.
Interview with the DOC confirmed the licensee failed to ensure that there were a range of continence care products available and accessible to residents and staff at all times when it took greater than 20 minutes to obtain a continence care product. [s. 51. (2) (f)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that that all food and fluids in the food production system were prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality.

On April 5 and 6, 2016, at the lunch time meal service, the Inspector observed two different PSW's add one heaping spoonful of a thickener to a resident's purred soup. The thickening agent was stirred in with the spoon and noted to change the texture and appearance when it created large lumps in the soup. The lumpy soup was fed to the resident. Interview with the dietary cook on the day of the meal services confirmed the soup was already prepared to preserve taste, nutritive value, appearance and food quality and that the thickening agent was not to be added to the soup. The cook confirmed the thickening agent would create lumps, when stirred in by spoon to a pureed soup, and would not preserve the texture, affecting taste, and appearance of the soup. [s. 72. (3) (a)]

2. The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods to, (b) prevent adulteration, contamination and food borne illness.

On April 6, 2016, at approximately 1830 hours the inspector observed a fluid cart that contained two closed bags and one open bag of milk, unaccompanied on the elevator (Heddon Hall location). This elevator was identified by front line staff as the elevator that was used and accessed by residents to attend recreational activities on the lower level. The milk bags were not on ice or noted to be on a cooling agent. The evening meal service was observed to commence at 1700 hours and it was undetermined how long the unsupervised milk was noted to be on the cart in the elevator. The elevator was not key coded, and provided non-protected access by residents on both the first and second floor to the milk products for a period of undetermined time.
Interview with the Dietary manager confirmed the fluids were not to be left unattended on the elevator. [s. 72. (3) (b)]

WN #16: 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. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Resident #202's plan of care indicated the resident required one staff assistance with their meals. The resident had a medical history that included an inability to eat meals by them self. The resident was identified in the most recent nutritional assessment in March 2016 as a nutritional risk. In April 2016 at the evening meal service, the resident received a modified textured meal that was placed in front of them. Staff #100 was noted to feed another resident at the table while resident #202 sat with their meal in front of them for 20 minutes without being assisted. Resident #035 was observed to have their therapeutic textured meal placed in front of them at the April 2016 evening meal service. The resident was identified in their most recent nutritional assessment as being at a nutritional risk and had a potential for an inability to eat independently. Staff #102 was observed to feed two other residents at the same table while the resident sat for 45 minutes and did not touch their meal. Staff member #102 left the table and the dining room. Staff member #100, after feeding two other residents at a separate table, came and sat beside resident #035 and fed the resident 3/4 of their meal. The resident was observed to say that their meal tasted good and they were hungry when the staff member commenced feeding them. Interview with the PSW # 100, 102 and registered staff #102 confirmed resident #035 and #202 required assistance with eating and drinking and were served a meal when there were no staff members available to provided assistance. [s. 73. (2) (b)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (4) For the purposes of subsection (3), but subject to subsection (5), the minimum number of hours per week shall be calculated as follows: M = A × 8 ÷ 25 where, "M" is the minimum number of hours per week, and "A" is,
(a) if the occupancy of the home is 97 per cent or more, the licensed bed capacity of the home for the week, or O. Reg. 79/10, s. 75 (4).
(b) if the occupancy of the home is less than 97 per cent, the number of residents residing in the home for the week, including absent residents. O. Reg. 79/10, s. 75 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a nutrition (Dietary) manager was on-site at the home working in the capacity of the nutrition manager for the minimum number of hours per week, without including any hours spent fulfilling other responsibilities.

The minimum number of hours per week were calculated as follows:

M=Ax8/25

Where,

"M" was the minimum number of hours per week, and
"A" was,

(a) if the occupancy of the per home was 97 per cent or more, the licensed bed capacity of the home for the week, or
(b) if the occupancy of the home was less than 97 per cent, the number of residents residing in the home for the week, including absent residents.

The worked nutrition manager hours were reviewed from February 1 to April 17, 2016.

The week of February 22 to 28, 2016, the minimum required work hours were calculated as 28 hours and the worked nutrition manager hours were 22.5 hours.
The week of March 14 to March 20, 2016, the minimum required work hours were calculated as 28 hours and the worked nutrition manager hours were zero.
The week of April 11 to April 17, 2016, the minimum required work hours were calculated as 28 hours and the worked nutrition manager hours were zero.

In an interview with staff #104 and #124 on April 13, 2016 and staff #125 on April 19, 2016, it was shared that the Nutrition manager was not replaced when they were off and that no coverage was provided by anyone in the home who worked in the capacity of the nutrition manager that did not include any hours spent fulfilling other responsibilities. (583) [s. 75. (4)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums

Specifically failed to comply with the following:

s. 77. (2) For the purposes of subsection (1), but subject to subsection (3), the minimum staffing hours shall be calculated as follows: M = A × 7 × 0.45 where, "M" is the minimum number of staffing hours per week, and "A" is,
(a) if the occupancy of the home is 97 per cent or more, the licensed bed capacity in the home for the week, or O. Reg. 79/10, s. 77(2)
(b) if the occupancy of the home is less than 97 per cent, the number of residents residing in the home for the week, including absent residents. O. Reg. 79/10, s. 77(2)

Findings/Faits saillants :

1. The licensee failed to ensure that there were sufficient food service workers for the home to meet the minimum staffing hours.

The minimum number of hours per week were calculated as follows:

M=Ax7x0.45

Where,

"M" was the minimum number of hours per week, and

"A" was,

(a) if the occupancy of the per home was 97 per cent or more, the licensed bed capacity of the home for the week, or
(b) if the occupancy of the home was less than 97 per cent, the number of residents residing in the home for the week, including absent residents.

A review of food service workers regular scheduled hours for 2016 identified four

food service staff were scheduled daily for 6.5 hours, totalling 182 scheduled hours per week. A review of the cooks regular scheduled hours for 2016 identified two cooks were scheduled daily for 7.5 hours, totalling 105 scheduled hours per week. Total scheduled food service hours per week were calculated as 287 hours per week.

The homes minimum required hour per week when the home was at 97 per cent capacity were calculated as 287 hours.

1) The week of March 21 to March 27, 2016, the minimum required work hours were calculated as 274 hours and the worked food service worker hours were 272.5.
2) The week of March 28 to April 3, 2016, the minimum required work hours were calculated as 277 hours and the worked food service worker hours were 274.5.
3) The week of April 11 to April17, 2016, the minimum required work hours were calculated as 287 hours and the worked food service worker hours were 282.75.

In an interview with staff #104 it was confirmed that the minimum food service worker hours were not met.
In an interview with the Administrator on August 11, 2016 this non compliance was confirmed. (583) [s. 77. (2)]

WN #19: The Licensee has failed to comply with LTCHA, 2007, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (1) Every licensee of a long-term care home shall ensure that,
(a) a package of information that complies with this section is given to every resident and to the substitute decision-maker of the resident, if any, at the time that the resident is admitted; 2007, c. 8, s. 78. (1).
(b) the package of information is made available to family members of residents and persons of importance to residents; 2007, c. 8, s. 78. (1).
(c) the package of information is revised as necessary; 2007, c. 8, s. 78. (1).
(d) any material revisions to the package of information are provided to any person who has received the original package and who is still a resident or substitute decision-maker of a resident; 2007, c. 8, s. 78. (1).
(e) the contents of the package and of the revisions are explained to the person receiving them. 2007, c. 8, s. 78. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, (d) any material revisions to the package of information was provided to any person who had received the original package and who was still a resident or substitute decision-maker of a resident.

A review of the licensee's Long Term Care (LTC) Admission Agreement information was conducted based on a complaint from a family member for resident #200. The Substitute Decision Maker (SDM) stated they noted a discrepancy in charges, from what the foot care provider charged the home, and what the SDM paid the home for the foot care services in 2014. The SDM stated they were provided two different reasons for the price variance and had no knowledge of any changes to the foot care charges. The LTC Admission Agreement indicated on page two, under article II- Resident Responsibilities, 2.3, "The resident agrees to pay for all other services not funded by Government for which written authorization has been obtained. On admission, the resident shall authorize in Schedule "B" which unfunded services are requested. The price of these services will be set out in Schedule 'B" or as amended from time to time on notice to the resident of price changes".

Resident #200 was admitted to the home in 2009. A review of Schedule B, Unfunded services, for resident #200 did not identify the price for the Chiropody/Podiatry/Professional Foot Services as stated in the Admission

agreement.
Three other admission agreements were reviewed for residents:
1. Resident #019- admitted 2008,
2. Resident #011- admitted 2008,
3. Resident #026-admitted 2015

A review of the admission agreement for Resident #019 and Resident #011 had not identified the price for the Chiropody/Podiatry/Professional Foot Services as stated in the Admission Agreement. An interview with staff #104 confirmed the home had not identified the price for foot care services in the Admission Agreement's for three of the four residents based on their dates of admission of 2008 and 2009. Staff #104 confirmed that the Long Term Care (LTC) Admission Agreement had been amended to include charges for resident's foot care services for all admissions on a "go forward' basis in 2013/2014. Resident #026's Admission agreement (admitted 2015) had included the foot care prices. Interview with staff #104 confirmed these revisions to the package of information had not been provided to any person who had received the original package (#011, #018, #200) and who were still a resident or substitute decision-maker of a resident. [s. 78. (1) (d)]

WN #20: The Licensee has failed to comply with LTCHA, 2007, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Findings/Faits saillants :

1. A licensee failed to ensure that they did not accept payment from or on behalf of a resident for anything that the licensee was prohibited from charging for under subsection (1) and shall not have caused or permitted anyone to make such a charge or accept such a payment on the licensee's behalf.

Interview with the home's Administrator confirmed the Licensee entered into an agreement with Weller Ainsworth Chiropody Profession Corporation (WACPC) in 2014 through June of 2015. WACPC provided advanced foot care services for residents with identified needs. The licensee provided four invoices for review, that were submitted by WACPC for July 2014, September 2014, November 2014 and January 2015. A review of these documents indicated the provider invoiced to the licensee a fee of $25.00 per resident visit. The rate was then discounted, by the provider, $5.00 per resident visit. A total of 309 resident visits at $25.00 per visit for a total of $7,725. $7,725 less the $5.00 per visit (5.00 x 309 visits= $1545) resulted in a charge to the licensee for $6,180. Interview with the home's office manager indicated the discount by Weller Ainsworth Chiropody Profession Corporation was for portering the individual residents to the provider for their foot care service. The foot care service was provided to the resident within the long term care home's resident designated area. A review of the Licensee list of ancillary charges documents, that corresponded with each of the invoicing periods as stated above, indicated the licensee charged $26.00 per resident visit (309 visits x $26.00= $8,034, a difference of $1,854). Interview with staff #104 confirmed the portering of residents had been provided by the home's front line staff. In March 2015 a complaint was received by the licensee from a resident's SDM indicating a concern regarding the difference between the billing of the foot care provider to the licensee and the charges to the resident from the Licensee. The SDM stated they were upset when they were told, by the licensee, that there was a charge for the home's staff to porter the resident downstairs to the foot care provider. Interview with front line staff and observation of resident care indicated the home's staff portered residents to other resident areas within the long term care home, including the basement level, for recreational activities, church services and physiotherapy activities. Interview with the Administrator confirmed the licensee had identified the variance between the foot care provider charges and the home's resident billings and ceased all charges for resident portering within the long term care home. The Administrator confirmed the licensee failed to ensure that they did not accept payment from or on behalf of a resident, for anything that the licensee was prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. [s. 91. (4)]

Issued on this 22 day of September 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 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 Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : ROBIN MACKIE (511) - (A1)

Inspection No. / No de l'inspection : 2016_250511_0006 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 008291-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Sep 22, 2016;(A1)

Licensee / Titulaire de permis : CVH (no.1) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : WEST PARK HEALTH CENTRE
103 Pelham Road, St Catharines, ON, L2S-1S9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Cindy Sheppard

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To CVH (no.1) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. Duty to protect

Order / Ordre :

The licensee shall ensure that all residents are protected from abuse from resident #609. This would include ensuring effective communication of assessments, reassessments, interventions and progress notes to the health care team. The licensee shall ensure there is an accurate and updated written plan of care that sets out clear directions to staff and others who are in contact with resident #609 in regards to their responsive behaviours and triggers for behaviours. The Licensee's remaining direct care staff shall be trained in mental health issues, including caring for persons with dementia and behaviour management.

Grounds / Motifs :

1. The licensee failed to protect all resident from abuse.

The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect to the actual harm or risk of harm that the identified residents experienced, the scope of one isolated incident, and the Licensee's history of non-compliance of s. 19. (VPC) from their 2015 Resident Quality Inspection.

1) A review of a critical incident, reported by the home, identified that on a specific day in 2015 resident #609 was witnessed to demonstrate a responsive behaviour to resident #608, which caused resident #608 to fall to the floor and sustain an injury. Resident #608 was sent to hospital for an assessment. The progress notes documented on the day of the incident indicated resident #608 sustained a physical

injury as a result of the altercation.
During a review of resident #609's progress notes it was identified that there were no documented notes for resident #609 during a three week time frame surrounding the incident. In an interview with the Director of Care (DOC) on April 22, 2016, it was confirmed that resident #609's physical responsive behaviour, demonstrated at the time of the incident, was not documented. It was also confirmed that actions taken to respond to resident #609's demonstrated responsive behaviour, including reassessments and interventions and resident #609's responses to the interventions, were not documented.
A review of resident #609's progress notes, documented the month before the identified specific incident, identified they had a previous altercation with another resident, when the other resident tried to enter resident #609's room. A review of resident #609's progress notes, documented the month after the incident, identified that resident #609 had another physical altercation which resulted in a resident's fall to the floor, when the resident entered resident #609's room.
A review of resident #608's plan of care identified they had known verbal and physical responsive behaviours and frequently wandered the halls and into other residents' rooms. Resident #608 previously sustained an injury two months before the specified incident, when they wandered into resident #602's room and an altercation occurred which caused resident #608 to fall to the floor.
A review of resident #609's plan of care identified the plan was not revised to identify the physically responsive behaviours until approximately one month and a half following the initial incident. In an interview with the RAI co-ordinator it was confirmed that resident #609's quarterly review assessment, completed approximately four months later, did not identify resident #609's physical responsive behaviours. In an interview with the DOC on April 22, 2016, it was confirmed that resident #609 had not been referred to, or followed by, Behavioural Supports Ontario (BSO) at the time of their demonstrated physical responsive behaviours.

2) A review of a critical incident and the progress notes documented on a day in 2015, identified that resident #609 was observed to have a physical altercation with resident #040 during a meal service.

An interview with registered nursing staff, who was present at the time of the incident, was completed on April 20, 2016. It was identified that resident #040 and resident #609 had sat beside each other at the same table in the dining room. Resident #609 was observed to become verbally responsive towards resident #040. The verbal responsive behaviours between resident #609 and #040 escalated into a

physical altercation. Resident #609 removed them self from the dining room after the incident.

The documented progress notes and critical incident report indicated the first staff interventions were noted to take place after resident #609 left the meal service.

Resident #040 was assessed to have an injury that required treatment by the Long Term Care physician. The resident was monitored and the physician recommended that resident #040 be transferred to hospital but the resident declined.

Prior to this incident resident #609 was known to have demonstrated verbal and physical responsive behaviours which caused injuries to other residents and resident #040 had known verbal responsive behaviours. A review of resident #609's care plan identified the plan was not reviewed or revised after the incident, which was confirmed in an interview with the DOC on April 22, 2016.
In an interview with registered nursing staff #119, on April 20, 2016, it was shared that resident #040 and #609 remained at the same dining table after the incident. In a progress note documented by the Dietary Manager it was identified that resident #609 had requested to be moved to a new table.

A review of the BSO notes documented in 2015 identified the BSO had followed resident #040 in relation to strategies for being resistive to care and verbally responsive to staff. In an interview with the DOC, on April 22, 2016, it was confirmed that the BSO had not provided interventions on how to manage resident #040's verbal responsive behaviors. It was confirmed that the incident between resident #040 and #609 had not been communicated to the BSO when they had spoken to registered staff in relation to resident #040 demonstrated responsive behaviours.
In an interview with the DOC it was confirmed that resident #609 had not been referred to, or followed by BSO, at the time of their demonstrated physical responsive behaviours.
The education attendance records for responsive behaviors and gentle persuasive approaches were reviewed for 2015. It was identified 42 out of 80 direct care staff had not received training. In an interview with staff #126, on April 21, 2016, it was confirmed that all staff that provided direct care to residents had not been trained on mental health issues, including caring for persons with dementia and behavior management. (#583) [s. 19.] (583)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 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 :

Sep 15, 2016(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 shall ensure the staffing plan will, (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. This staffing plan will specifically meet the needs of residents and ensure that residents receive two baths per week of their choice, will be assisted with feeding when their food is placed in front of them and have their toileting needs met by a method of their choice.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan provided for (a) a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this regulation.

The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (2), in keeping with s.299(1) of the Regulation, in respect to the actual harm or risk of harm that the residents experienced, the scope of one isolated incident, and the Licensee's history of non-compliance (unrelated) from their Resident Quality Inspection.

A) Resident #202's plan of care indicated the resident required one staff assistance with their meals. The resident had an inability to eat meals by themselves. On a day in 2016, at a meal service, the resident received a modified textured meal that was placed in front of them. Staff #100 was noted to feed another resident at the table while resident #202 sat with their meal in front of them for 20 minutes without being assisted. Staff member #100 indicated the licensee had recently reduced the front line, PSW, staffing support on the evening shift by eliminating a 1630-2030 hours position and a 1400-2000 hours position. The staff member indicated they were unable to meet the feeding needs of the residents due to staffing changes.

B) Resident #035 was observed to have their therapeutic textured meal placed in front of them on a date in 2016 during a meal service. The resident was identified in their most recent nutritional assessment as being at a nutritional risk and had a potential for an inability to eat independently. Staff #102 was observed to feed two other residents at the same table while resident #035 sat for 45 minutes and did not touch their meal. Staff #102 left the table to complete other registered nursing care related tasks. Staff member #100, after feeding two other residents at a different table, came and sat beside resident #035 and fed the resident three quarters of their

meal. Interview with PSW #100 confirmed resident #035 required assistance with eating and did not have a staff member available to assist them for 45 minutes. Interview with staff #102 confirmed they were unable to consistently feed residents that required assistance when registered nursing tasks required them to leave the dining room. Staff #102 confirmed they were the only registered nurse responsible for the residents of the home when they worked on the specified date in 2016. Interview with the DOC confirmed the registered nursing tasks, if required by staff #102 during the dining service, would supersede feeding residents.

C) During a meal service in 2016 three PSWs were noted to be sitting with residents that required assistance with feeding them their desserts, in one area of the dining room while the other side of the dining room remained unsupervised with greater than 10 residents that still had a portion of their meal in front of them. Interview with the three PSWs confirmed they were required to assist feeding the residents their desserts and there were no staff members available to supervise the other section of the dining room, that was out of view of the three staff members, for greater than 10 minutes.

D) During the initial lunch service on a day in 2016 it was observed that the Food Service Supervisor fed two residents their lunch meal. The Administrator was also observed to enter and leave the dining service and occasionally served meals to residents from the servery. Interview with the Food Service Supervisor confirmed they did not provide this assistance seven days a week/three meals per day, were not part of the daily front line staffing schedule and would help out only when they were able, in order to provide assistance with feeding, as needed . The Administrator confirmed management staff did not provide meal service assistance as part of the routine meal service 24/7 days a week.

E) During observation of two separate lunch observations and one dinner meal service, during the RQI in 2016, the Inspector observed two different PSWs add thickener to the fluids of resident #201 and #202, whom required therapeutic textured fluids according to their most recent plans of care. A review of the clinical record indicated resident #201 and #202 had been identified as a nutritional risk. The staff members were observed adding one and two scoops to the fluids with a spoon, stirred the fluid and immediately proceeded to administer the fluids. Resident #202 initially coughed and the staff member stopped pouring it in the resident's mouth and stated " this is too thin" and proceeded to add two more rounded spoonfuls to the fluid. Both residents received fluids that were too thin as the thickener did not

thicken in the time between when they added it to the fluid and when they gave it to the resident, which was approximately 30 seconds to one minute. The staff stated they used the utensils that were available on the table and would use anywhere between one heaping spoonful to up to four to thicken the resident fluids.
The staff members were observed to not accurately measure the amount of the thickener or wait the required time, as per the thickener instructions prior to feeding the resident. The fluids were not provided as per the physician ordered consistency of thickened fluids at these meal services. The recipe and directions for the thickening product instructed the staff to measure the liquids and the dry product thickener before thickening and to use level dry measuring utensils for the thickener. The liquid was to be stirred 'briskly' with a fork or a wire whisk and to allow three to five minutes for liquid to reach the desired consistency. Milk was advised that it could take up to 30 minutes for the desired consistency to be reached. Interview with both PSWs indicated they were unaware of the time frames required to allow the fluids to thicken and indicated they did not have the time to obtain the proper measuring utensils, measure and wait 5 to 30 minutes for the fluids to thicken prior to assisting residents to drink their fluids at the point of service.

F)
a. During an interview for resident #019 the SDM indicated their family member required staff to assist the resident with toileting and often had to wait over 30 minutes for staff to assist the resident. Family reported the resident had incontinent episodes while waiting for staff assistance.
b. During a resident interview for resident #026 they stated there used to be more staff to assist them when they rang the bell to be toileted and now, by the time the staff arrived, it was 'too late' and they would have been incontinent. They stated they were no longer toileted by a method of their choice.
Interview with staff number #116, confirmed that resident #019 and #026 both had been identified by the home to require staff assistance for toileting. Staff #116 confirmed there were no physical reasons that either of these residents could not be toileted by a method of their choice with staff assistance. Interview with staff #117 indicated both residents would be safe to toilet by a method of their choice and there would be no physical safety risk to prevent toileting by staff. Staff #116 confirmed the staff would not have the time to toilet, using the residents method of choice, as required by the residents.

G) During the 2016 RQI observation, approximately an hour after a meal service, resident #024 was observed sitting in their wheelchair, beside their bed with the

lights off. The resident was quiet with their eyes closed and did not appear to be distressed. A review of their clinical record indicated the resident had risk factors for skin to breakdown that included a history of incontinence, mobility deficit, inability to reposition them self and a severe cognitive deficit. The clinical record indicated they had an identified alteration in their skin integrity at the time of the observation. Interview with PSW #112 and #115 confirmed the resident had been sitting at their bedside since the meal service and stated they were to return them to their bed immediately after meal service as they were to be only up for specified time periods. The two PSWs stated they had not assisted the resident to return to bed as required in the plan of care as they had a number of residents that required a two person lift. The staff members confirmed they were unable to provide resident #024 their care, that was consistent with the resident's assessed care and safety needs, until they finished the other residents more than one hour after the resident had consumed their meal. They stated that the PSW breaks started and they would be unable to provide this resident assistance until other staff returned to the floor as there would be no other PSW available on the floor to assist with other resident care needs. The PSWs stated they were frustrated as they felt they were having difficulty meeting the increasing resident needs and had a hard time meeting the current needs of the residents with the recent decrease in staffing.

H) During the RQI in 2016 resident #030 was observed to be sitting in front of the shower room in a hospital gown that had food stains and crumbs on their front for approximately 35 minutes. Interview with staff #115 indicated it was the resident's shower day and that they had placed the resident there to wait for their shower. Staff #115 stated they had planned to provide the resident their shower when the resident was placed by the shower room door. The shower room was empty during this time and the staff member indicated they had not had the time to start the resident's shower as they had been running behind from the meal service and the staff breaks had started. They confirmed they would be unable to provide the resident their shower until other staff members came back approximately two hours later.

I) In an interview with resident #600's Substitute Decision Maker (SDM), during the RQI in 2016, it was shared that resident #600 was not bathed as per their preference on a specific date in 2016. The SDM stated they were told the unit was short Personal Support Workers and that when this occurred residents would receive bed baths. A review of the plan of care identified that resident #600 preferred to have a shower. In an interview with staff #113 and #114, on a day during the RQI in 2016, it was confirmed resident #600 received a sponge bath and was not bathed as per

their preference.

The day shift bath schedule, for a date during in 2016, was reviewed and the bathing preferences for the residents scheduled to be bathed were reviewed in the plan of care. It was identified resident #603, #025, #605, #606, #036 and #607 preferred a tub bath and resident #604 and #029 preferred a shower. In an interview with staff #113 and #114 it was confirmed that the residents had full body sponge baths and were not bathed by a method of their preference as they did not have the time.
A memo dated in 2016, identified the home would not be replacing shifts. In an interview with staff #124 it was confirmed that the regular PSW complement on the specified date was four staff on day shift and one staff was unable to come in and they were not replaced per the direction of the home. (583)

Interview with staff # 100, #102, #116, #117, #112 and #115 indicated they were unaware of a new staffing plan that would direct them on how to continue to meet care needs when the staffing reductions had occurred.

Interview with the Administrator confirmed the licensee had decreased front line staffing by 217 hours biweekly that commenced March 2016. These hours consisted of one fulltime PSW and their relief staff, from second floor evening shift 1400-2000 hours, and two 1630-2030 hours from each floor. The day shift, second floor, was further reduced on March 30th by seven hours (70 hours biweekly) when they moved a PSW team member who had been working a 0600-1330 hour shift from days to nights. These hours where not replaced. This PSW duties assignment was reviewed and indicated the resident had been assigned five team members for morning care and assisted in the dining room. The Administrator confirmed the front line staffing compliment will be further reduced by another fulltime equivalent for days on May 9, 2016, bringing the PSW staffing compliment to four full time staff members for first floor (46 residents) and second floor (45 residents) on days. On evenings the staffing will be three PSW for 46 residents on first floor and three PSWs on second floor for 45 residents on evening.
The Administrator stated the 217 hours were reduced to accommodate a previous reduction in the Case Mix Index (CMI) that went from .96 to .93. According to the Canadian Health Care Institute the Case Mix index (CMI) uses case mix methodologies to categorize residents into statistically and clinically homogeneous groups based on the collection of clinical and administrative case data by a long term care home. The CMI value is one factor used to determine the allocation of resources to care for and/or treat the residents in health care facilities. The case mix

methodologies and their accompanying resource indicators are used to effectively plan, monitor and manage the services they provide. The Administrator stated the home's current CMI as of April 4, 2016 was .99 and believed that the previous reduction in CMI was based on inaccurate coding. Clarification with the Administrator and the DOC confirmed that inaccurate coding through the CMI would not necessarily reflect the current care need of the residents today.
In addition to the 217 hour decrease in front line hours there was direction from the licensee to not replace staff without prior authorization. A review of a memo from the Administrator to the staff, dated March 22, 2016, Subject line: "Drop in Funding" and "Due to the significant drop in our CMI, we will not be replacing shifts, using Agency staff or offering over time without the approval from the Administrator. A review of the document, provided by the home, titled "Rotation Health Care Aides" showed the shifts and hours that staff were not replaced from the period of March 21, 2016 to April 17, 2016. The following staffing details for the hours not replaced on the floor was confirmed by staff # 124 (ward clerk/staff scheduling) and is as below:
PSW
March 21 two shifts: 15 hours, March 22 one shift: 7.5 hours, March 23 one shift : 7.5 hours, March 27 one shift: 7.5 hours, April 1 one shift: 7.5 hours, April 9 one shift: 7.5 hours, April 16 one shift: 7.5 hours and April 17 one shift: 7.5 hours
RPN
March 22 one shift: 7.5 hours, March 23 one shift: 7.5 hours, March 24 one shift: 7.5 hours
Housekeeping
April 11 one shift: 7.5 hours
Recreation Staff
March 24, 27, 31, April 1, 8, 9, 10,12 and 13, 2016: 7 hours each shift (63 hours total)

There was a total of 54 hours of PSW hours, 22.5 hours of RPN and 63 hours of recreation staff that were not replaced for the period of March 21, 2016 to April 17, 2016. This is a total of an additional 139.5 hours to the 217 reduced hours. [s. 31. (3)] (511)

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

Sep 15, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 22 day of September 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : ROBIN MACKIE - (A1)

Service Area Office /
Bureau régional de services : Hamilton