Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur 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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 31, 2019	2019_643111_0015	031239-18, 031674-18, 000064-19, 000065-19, 000066-19, 000067-19, 003150-19, 003603-19	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

The Willows Estate Nursing Home
13837 Yonge Street AURORA ON L4G 3G8

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 10-14, 17-19, 21, 24-25, 2019.

During this inspection, there were two critical incidents (CIR-Log #003603-19) and

(CIR-Log #031239-18) which both related to the same resident for a fall incident and unexpected death.

A Voluntary Plan of Correction (VPC) under O.Reg. 79/10, s.8(1)(b) and s.101(3), identified in this inspection (Log #003603-19, 003150-19 and 031239-18) will be issued under a Complaint Inspection #2019_643111_0015 (Log #030009-18) concurrently inspected during this inspection.

There were four follow up inspections completed concurrently during this inspection as follows:
-Log #000064-19 related to a safe and secure home.
-Log # 000065-19 related to windows in the home.
-Log # 000066-19 related to the hydration program.
-Log # 000067-19 related to the hot weather prevention program.

In addition, there were two complaints inspected concurrently during this inspection as follows:
-Log # 031674-18 related to staffing.
-Log # 003150-19 related to alleged improper care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care, the Clinical Care Coordinator, the Director of Operations Omni, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers (HSK), Environmental Services Manager (ESM), Dietitian, Activity Aide (AA), Nutritional Care Manager (NCM), Cook, Nursing Administrative Services Manager (NASM), families and residents.

During the course of the inspection, the inspector reviewed health care records of current and deceased residents, reviewed complaints, reviewed staffing schedules, reviewed staff training records, observed meals, observed the exterior of the home, observed cooling areas/dining rooms, observed windows and reviewed the following home policies: pest control, complaints, hydration program, hot weather prevention program, prevention of abuse and neglect.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 VPC(s)**
- **0 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. 16.	CO #002	2018_414110_0014	111
O.Reg 79/10 s. 20. (1)	CO #004	2018_414110_0014	111
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2018_414110_0014	111
O.Reg 79/10 s. 68. (2)	CO #003	2018_414110_0014	111

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A critical incident report (CIR) was submitted to the Director on a specified date, for a fall incident with resident #001, that resulted in a transfer to hospital. The CIR indicated on a specified date and time, the resident had sustained a fall in a specified area while being assisted by PSW #102. The CIR indicated RN #100 and RPN #101 responded to the incident.

A complaint was also received by the Director, regarding the same incident.

Review of the written plan of care for resident #001, indicated the resident required a specified number of staff assistance for transfers and bathing and was at risk for falls.

Review of the progress notes for resident #001 indicated, on a specified date and time, RPN #101 was notified by PSW #102 that resident #001 had sustained a fall in a specified area, while being assisted by the PSW. The resident sustained an injury to a specified area and was transferred to hospital at the SDMs request.

During an interview with PSW #102, they indicated resident #001 required the use of a specified lift, for all transfers and bathing, with the use of a specified number of staff assisting. The PSW confirmed on a specified date and time, they had not completed the residents care as per the plan of care. The PSW confirmed the resident sustained a fall with an injury as a result and they immediately reported the fall to RPN #101. The PSW confirmed awareness the resident was at risk of falls.

During an interview with RPN #101, they indicated resident #001 required the use of a specified number of staff assistance with all personal care due to impaired mobility, specified diagnosis and risk of falls. The RPN confirmed on a specified date and time, PSW #102 had reported resident #001 had sustained a fall while they were providing the resident care. The RPN confirmed the PSW had not provided the resident their care according to their plan of care.

During an interview with the Administrator, they indicated the former DOC had completed the investigation into the fall incident involving resident #001 and the DOC determined that the PSW failed to follow resident #001's plan of care.

The licensee failed to ensure that resident #001 was provided care according to their plan of care, resulting in a fall with injuries to specified areas.

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 care set out in the plan of care is provided to the resident, as specified in the plan,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

The licensee has failed to ensure that all assistive and positioning aids were used in accordance with manufacturers' instructions.

A critical incident report (CIR) was received by the Director for a fall incident that occurred on a specified date. The CIR indicated resident #001 had a fall while being assisted with care by PSW #102. The resident sustained injuries to specified areas, as a result.

A complaint was also received by the family of resident #001 regarding the same incident.

During an interview with PSW #102, they indicated on a specified date and time, they were provided care to resident #001 in a specified mobility aid when the resident sustained a fall. The PSW confirmed they were not using a restraining device, as per the manufacturer's instructions, as there was none available. The PSW indicated the restraining device was now available as a result of the investigation with the former DOC and the Administrator. The PSW indicated they reported the fall to RPN #101.

During an interview with RPN #101, they confirmed that on a specified date, when resident #001 had sustained a fall while in a specified mobility aid, they confirmed the mobility aid was not used, as per the manufacturer's instructions. The RPN indicated a

number of the same mobility aide's did not have the required restraining devices available for a period of time, at the time of the fall with resident #001 and the restraining devices were purchased after the incident occurred.

Review of the EZee Life Tilt (specified mobility aid) user manual indicated on page 8, the mobility aid was to be placed in a specified position when the resident was in the aid and required the use of a restraining device. On page 11, under safety information, always use the supplied restraining device for safety and do not leave the resident unattended.

During an interview with the Administrator, they indicated the DOC that was in place at the time of the fall with resident #001, no longer worked in the home. The Administrator indicated the former DOC had completed the investigation into the fall incident. The Administrator indicated the former DOC determined that the mobility aid had not been used as per the manufacturer's instructions at the time of the fall. The Administrator indicated no awareness if there was a restraining device applied or available at the time of the fall.

The licensee failed to ensure that staff used equipment, in accordance with the manufacturer's instructions as the restraining device was not in place at the time of the fall, the mobility aid was not tilted and the resident was left unattended.

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 assistive and positioning aids were used in accordance with manufacturers' instructions., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the person who had reasonable grounds to suspect that Improper or incompetent treatment of care of a resident, that resulted in harm or a risk of harm had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A critical incident report (CIR) was submitted to the Director on a specified date, for a fall incident that resulted in injury for which the resident was transferred to hospital. The CIR indicated on a specified date and time, resident #001 had sustained a fall with injuries to specified areas. The CIR was not submitted to the Director until six days after the incident occurred. .

During an interview with the Administrator, they indicated the former DOC had completed the investigation immediately into the fall incident involving resident #001 and concluded the investigation four days later, that PSW #102 had provided improper care. The Administrator was not aware that the CIR was reported as a fall with an injury and not as improper care that resulted in an injury to the resident. The Administrator indicated the home did not report the improper care immediately to the Director and should have been.

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 person who had reasonable grounds to suspect that Improper or incompetent treatment of care of a resident, that resulted in harm or a risk of harm had occurred, immediately reported the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

An anonymous complaint was received by the Director on a specified date, regarding

ongoing short staffing of PSWs on a specified area, on specified shifts, that resulted in resident care not being provided. The complainant also indicated that staff were being directed to improperly document that care had been provided, despite the care not being completed, due to short-staffing.

The home has 84 beds, with 42 residents on two floors. Review of the nursing Contingency plan-staffing replacement (reviewed February 15, 2019) indicated for PSWs: during any absence on any shift, another staff will be offered the shift. Failing this, staff will work 1 short PSW on days and evenings. If 2 PSW's are absent with no staff PSW replacements, we will utilize one agency PSW to ensure safety on days and evenings.

During an interview with PSW's #109 and #110, they both confirmed that a specified area was frequently working short-staffed of PSWs, on specified dates and shifts. Both PSW's indicated on a specified date, they had only two out of four PSW's working on a specified shift and were required to provide care to 42 residents. Both PSW's indicated that it was impossible to provide proper care to 22 residents per PSW, when they are working short-staffed. Both PSW's confirmed they were directed by the charge nurse to not provide specified care, for specified residents and were directed to document that the care was provided, despite the care not being provided. Both PSW's indicated resident #003 was informed on a specified date, that care would not be provided as per their plan of care, as a result of short-staffing and was upset as a result.

During an interview with PSW # 111, they confirmed a specified area was frequently working short-staffed with PSW's and have been directed by nursing management, to only provide care in a specified manner, when they are working short staffed.

During an interview with RPN #112, they confirmed that during specified dates, a specified unit was working short-staffed with PSW's and resulted in the RPN directing the PSW's to complete care in a specified manner, to specified residents. The RPN indicated they provided this direction as the PSWs were not able to provide proper resident care when there was only two PSWs to complete care for 42 residents. RPN #112 indicated on specified dates that they had been working with two out of four PSWs on a specified shift, to provide care and care was not provided to the residents, as specified in the plan.

During an interview with RPN #106, they confirmed awareness that on specified areas, there has been short-staffing with PSWs. RPN #106 indicated awareness that there had been the odd bath that was not completed as a result. RPN #106 indicated they have

directed staff to document a bed bath was completed, only if the PSW completed the bed bath and if the resident agreed to the bed bath. RPN #106 indicated they attempt to replace PSW staff and also contact agency staff, but the agency haven't been able to provide many PSW's lately. RPN #106 indicated RN #113 was responsible for monitoring that residents were receiving their scheduled bath/showers.

Review of the staffing schedule for PSW's for a specified period, indicated a specified number of dates and shifts when there was one or more shortages of PSWs. In a three month period, there were 31 day shifts when they were not working fully staffed (7/8 staff) with PSWs and 14 of those day shifts, they were working with only 6/8 staff to care for 84 residents. During the same period, there were 22 evening shifts when they were not working fully staffed with PSWs and four of those evening shifts when they were working with only 6/8 PSWs to provide care to 84 residents.

During an interview with Nursing Administrative Services Manager (NASM), they indicated they complete the nursing schedules which includes the PSWs. The NASM indicated they have had a PSW shortage on day and evening shifts as there was currently four part-time vacancies, they just filled two part time vacancies, they don't have enough part times staff to fill for call-ins/vacancies/vacation and they have not received enough resumes for PSWs. They indicated they use TLC agency.

During an interview with the Administrator, they indicated no awareness when there was only two PSWs working on the floor for day or evening shifts and indicated the lowest the PSW staffing was only ever three out of four PSWs on either a day or evening shift. The Administrator indicated no awareness of any complaints received from residents, families or staff regarding the residents missing their bath/showers or related to short staffing. [s. 31. (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 the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

The licensee has failed to ensure that immediate action was taken to deal with pests.

On specified dates and at various times, the Inspector noted pests in various areas of the home.

During an interview with Housekeeper (HSK) #114, they indicated they were assigned to clean specified areas, confirmed awareness of pests in specified areas and indicated that they would have reported any pest activity to the Environmental Services Manager (ESM).

During an interview with HSK #115, they indicated that they were assigned to specified areas,confirmed awareness of pest activity in specified areas over a specified period of time and reported it to the ESM.

During an interview with the ESM, they indicated that they also cleaned specified areas as well as HSK staff. The ESM indicated that they noted pest activity previously but nothing recently. The ESM indicated no awareness of HSK staff reporting any new pest activity currently in the home. The ESM indicated they had monthly pest control services completed by their service provider and the last visit was on a specified date. The ESM indicated they also applied a specified pest deterrent, as a result of the Inspector noting pest activity in the home.

During an interview with the Administrator, they indicated they had notified the pest control on a specified date, regarding the pests, as a result of the Inspector informing them of concerns with pests in the home. The Administrator confirmed that the last visit by the pest control service provider, did not include specified areas where the pests were noted.

During an interview with the pest control service representative by the Inspector, they indicated they were not made aware of any concerns with pest during their last visit which required a special treatment to be applied both inside and outside of the home. The service representative confirmed a visual inspection verified that pests were present both inside and outside of the home and treatment was applied.

The licensee did not take immediate actions to deal with pests in the home, as they took actions as a result of pest concerns identified by the Inspector.

Issued on this 7th day of October, 2019

[redacted]

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

Original report signed by the inspector.