Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 26, 2020	2020_769646_0009	010545-20	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Hawthorne Place Care Centre
2045 Finch Avenue West NORTH YORK ON M3N 1M9

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

IVY LAM (646), NAZILA AFGHANI (764)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): Onsite on: May 28, 29, 30, 31; June 1, 2, 4, 8, 9, 10, 11, 15, 16, 17, 18, 19, 22, and 23, 2020. Offsite on: June 3, 5, and 24, 2020.

The following intake was completed during this complaint inspection:
Log #010545-20 related to alleged abuse, communication, continence care, dining service, housekeeping, infection prevention and control, laundry service, medication management, nutrition and hydration, palliative care, pest control, skin and wound, staffing, and training and orientation.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), acting Director of Care (DOC), Assistant Directors of Care (ADOC), Canadian Armed Forces (CAF) Senior Nursing Officers (SNOs), Senior Medical Technician (SMT) / CAF staff, CAF Augmented Civilian Care (ACC) Staff, Communicable Disease Investigator (CDI)/ Infection Control – Toronto Public Health, Regional Director of Operations – hospital, Manager of Core Housekeeping – hospital, Registered Nurses (RN), Agency RNs, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Agency PSWs, Registered Dietitians (RD), Food Service Manager (FSM), Food Service Supervisor (FSS), Dietary Aides, Cooks, Employee Engagement Specialist (EES), Staff Education Coordinator, Unit Clerk, Resident Assessment Instrument-Minimum Data Set (RAI-MDS) staff, Social Worker, Environmental Services Manager (ESM), Maintenance staff, Housekeepers, Laundry Aides, and residents.

During the course of this inspection, the inspector reviewed resident and home records, relevant policies and procedures, and conducted observations, including staff-resident interactions, transfers and repositioning, meal observations, resident care provision, shift reports, and laundry service and housekeeping.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Dining Observation
Hospitalization and Change in Condition
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **2 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007's plan of care set out clear directions to staff and others who provided direct care to the resident.

This inspection was initiated related to the 4th Canadian Division Joint Task Force (Central) (JTFC)'s Observation Report regarding concerns from the Canadian Armed Forces (CAF) Augmented Civilian Care (ACC) teams. Review of the home's Critical Incident System (CIS) showed the outbreak was declared in the home on a day in April 2020, by Toronto Public Health, and the outbreak was declared over on a day in June 2020. The CAF team was in the home between April to June 2020. Multiple concerns were raised by the CAF in the observation report above, including the delivery and quality of nutritional supplements for residents who require nutritional supplements.

Interview with CAF Senior Nursing Officer (SNO) #107 clarified that the incident had occurred only once and was for resident #007.

Review of resident #007's current diet order on their written plan of care and their Electronic Medication Administration Records (eMAR) showed the resident was to receive a specified amount of a nutritional supplement at identified times, but if the nutritional supplement was not available, an alternative nutritional supplement could be

used but the amount given needed to be reduced to meet the resident's nutritional needs.

Review of resident #007's progress notes showed the resident was given the alternative nutritional supplement at the reduced amount for five days. Review of resident #007's progress notes showed that on one of the five days, the regular nutritional supplement was not available, and the alternative was provided instead. No documentation was found for the other four days to explain why the resident was given the alternative nutritional supplement.

Review of the progress notes showed that an agency RPN had provided resident #007 with the nutritional supplement at the reduced amount, but did not specify whether it was the original or the alternative nutritional supplement. On another day, the same agency RPN documented the resident was provided a nutritional supplement at an amount that was not on any order, and the RPN did not specify if it was the original or the alternative nutritional supplement, or why they had changed the amount given to the resident.

The identified agency RPN did not work regularly in the home and the inspector was not able to interview the RPN.

Interview with Registered Nurse (RN) in charge of resident #007's unit stated that the resident should have been provided the original nutritional supplement, and only if the original runs out should they use the alterative. The RN further stated the order was written a while ago during a time when the original supplement was not readily available, and the staff needed the flexibility to use the alternative. The RN further stated that the order should be clarified, and the directions about using the alternative nutritional supplement for resident #007 should be removed, as the original nutritional supplement is regularly available.

Interview with the Registered Dietitian (RD) overseeing resident #007's nutritional care stated that the original nutritional supplement should be given to resident #007, and there was no reason for staff to provide the alternative to the resident as there had been no shortage of the original nutritional supplement. There was increased risk that resident #007 would not receive their required nutritional needs when the directions were not written clearly for staff members.

Interview with the acting Director of Care (DOC) showed that the nutritional supplement order did not provide staff with clear directions for resident #007. The acting DOC further

stated that resident #007's nutritional supplement order needed to be clarified to only include directions for the original nutritional supplement, to be provided at one amount, and if there were any issues or shortage, to notify the RD and provide a reason why the changes were needed, and this was not done. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other for palliative care of resident #033.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. The following concerns regarding palliative care were noted: Palliative care orders were not charted and were unknown for agency staff to follow.

A Palliative Performance Scale (PPS), was used to measure patients' performance status from 100% (healthy) to 0% (death) and provides information on the expected outcome for residents and the level of care a resident requires.

Review of resident #033's progress notes and PPS assessment (10%) in 2019, showed that resident #033 was on palliative care. The resident's PPS indicated that the resident was at end of life. In early 2020, resident #033's PPS score had improved to 40%, and showed that the resident was in a transitional stage.

Review of the resident's progress notes, and the pain evaluation summary, showed no indication of pain, discomfort or respiratory distress, and later, the resident tested positive for an identified disease.

Review of the resident's current electronic Medication Administration Record (eMAR), showed the resident was on medication for pain and comfort.

Review of Nutrition/Hydration Risk Assessment indicated resident #003's was at moderate nutrition/hydration risk.

Review of the care plan indicated resident #033's wishes expressed no Cardiac Pulmonary Resuscitation (CPR), however transfer to hospital decision will be made at the time.

Inspector #764 had interviewed RPN #108 and RPN #197, regarding resident #033's palliative status, and review of resident #033's care plan showed that resident #033 was

palliative, and wished to remain at LTC home, as an expected home death. No CPR, no transfer to hospital.

Review of the resident's plan of care indicated a new program and activity consideration related to palliative status/End-of-Life, including palliative 1:1 visits and spiritual support.

Review of the six-month Multi-Month Participation report showed the resident's attendance had participated in the following: friendly visits, 1:1 visits, and TV church service. No program calendar was available during identified disease outbreak in the home.

During interview with RPN #126, they stated that although the resident was on palliative care and receiving pain control medication, they had no pain and was taking fluids for the last few months.

During interview with RN #103, they stated that resident #033 was palliative for over a year, until the date of interview. They stated that resident #033's pain control was well managed, they were comfortable and taking fluids, but still on palliative care. They stated that resident #033 was not receiving any essential visitors.

During interview with SW #186, they stated that funeral arrangements were discussed with resident #003's family and was documented, but they did not receive any referral for the palliative care consultant per home's end-of-life program.

During interview with Program Manager #141, they stated that none of the residents were on palliative care in the home.

During interview with Program Volunteer #196, they stated that there were no church visits during the identified disease outbreak; some religious programs on television were provided, but there were not enough televisions to provide access for all the residents.

During interview with the acting DOC, they stated that if a resident has a PPS score under 20%, they would be considered palliative. Interview with the acting DOC stated that the staff did not collaborate in the assessment and implementation of resident #033's palliative status and care. [s. 6. (4)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their

assessments were integrated, consistent with and complemented each other.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. Concerns regarding nutritional care included: Lack of permanent staff and oversight, feeding status not posted and not readily available, inappropriate meals being served or fed to residents, and PSWs not providing enough time or assistance to residents who require feeding assistance.

In an interview, CAF SNO #107 specified that they had observed force-feeding or force-hydration of resident #013 who required thickened fluids was fed too quickly by RPN #177, and the SNO had asked the RPN to stop and took over feeding for the resident. The SNO was unable to specify the date of the incident. The SNO stated that other CAF staff had also observed force-feeding by other staff members. However, the SNO was unable to provide the names of the staff or residents. The SNO also stated that the home's staff were not always aware of what diets to provide for residents.

At the time of the inspection, resident #013 was no longer in the home. Further, RPN #177 was also no longer employed by the home.

Interviews with two RPNs who worked regularly on resident #013's floor stated that they were unaware of any incidents of force-feeding or force-hydration of residents by RPN #177. Interviews with two PSWs who worked regularly in the home during the months of April and May stated that they had neither observed nor were aware of any incidents of force feeding or force hydration of residents. Separate interviews with the Executive Director (ED) and acting DOC stated that neither the CAF staff nor any of the home staff had informed them of any incidents of force-feeding or force-hydration from staff to resident #013 or any other residents.

Interview with the ED specified that the dining rooms were not used during the outbreak beginning on a day in April 2020 and residents received meal service in their rooms. Interview with the Food Service Manager (FSM) specified that at the start of the meal service, PSWs should tell the Dietary Aides (DAs) the resident's name and choice preference, and the DAs should verify the resident, their diet, texture, allergies and preferences, then put the meal into a box labeled for the specific resident.

Resident #003 was included as part of the resident sample to inspect on the home's nutrition and hydration process for residents.

Review of resident #003's care plan on PCC at the time of the inspection showed resident #003 was to receive a regular diet with a modified diet texture and thickened fluids. Review of the progress notes showed on a day in May, RD #154 had temporarily downgraded resident #003's diet from regular texture to modified texture due to the resident's decline in status. On a later date in May, the RD further downgraded the resident's diet due to their continued decline, and had changed the resident's fluid consistency to thickened fluids on this date.

Observation of breakfast on a day in June 2020 showed that resident #003 was provided a less modified diet and thin fluids – both of which were different than what was in their current written plan of care.

Resident #003 was not cognitively able to be interviewed.

In an interview, PSW #194, who works regularly with resident #003, stated that the resident had been receiving the less modified diet texture and thin fluids for about one week. The PSW further stated that the resident's health status improved since earlier in May 2020, and the PSW had changed resident's diet to a less modified diet with thin fluids to encourage the resident's food intake. The PSW stated they had informed an agency RPN that resident #003 should be upgraded to a less modified texture as the resident's health status had improved and was not eating very much from the more modified diet texture. The PSW stated they thought the nurse would refer to the RD. The PSW did not know if the nurse had followed up with the RD. The PSW stated they had not used the Kardex, care plan, or dietary binder when ordering or serving the resident.

Interview with RD #154, stated that the registered staff whom the PSW had informed regarding resident #003's poor intake with the modified diet texture should have referred to the RD for an assessment, and the PSW should not have provided resident #003 with an upgraded diet different from what was in the resident's care plan without the RD's assessment and recommendation or order. Resident #003 was at increased risk of not being able to tolerate their diet when the nursing staff changed the resident's diet without referral or collaboration with the RD for a nutrition assessment of the resident.

Interview with the acting DOC stated that the nursing and dietary staff should collaborate to ensure that residents receive the diet and fluids as per their plan of care. The acting DOC further stated that this was not done for resident #003, when the staff upgraded resident #003's diet and provided it to the resident for one week without an RD's assessment and order. [s. 6. (4) (a)]

4. This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. Multiple concerns were raised by the CAF in the letter above, including the delivery and condition of nutritional supplements for residents who require nutritional supplements.

Interview with CAF SNO clarified that the incident had occurred only once and was for resident #007. The SNO was notified by RPN #118 in May 2020 regarding an issue with the condition of the nutritional supplement that resident #007 was given, and they were concerned that the supplement had expired.

Review of resident #007's progress notes and eMAR for the months of April and May 2020 did not show any documentation regarding issues with the resident's nutritional supplement and no nutrition/dietary referrals were made related to the nutritional supplements.

Observation of resident #007 by inspector #646 showed that the resident was provided their nutritional supplement at the amount as per their dietary care plan, and the supplement had not expired. No concern regarding the condition of the nutritional supplement was noted. A second observation of resident #007 on a later date showed that the resident was provided the right amount of the right nutritional supplement, and no concerns were noted regarding the condition of the nutritional supplement.

Three other residents who received nutritional supplements in the home were observed on two separate days, and no concerns were noted regarding the delivery or condition of their nutritional supplements.

The nutritional supplements in the storage room were inspected over two days, and none of the nutritional supplements in the storage were observed to be expired. Multiple types of nutritional supplements were also observed.

In an interview, RPN #118 stated that on the day of the incident, no concerns were noted when the RPN began their shift or did their rounds about one hour later. However, about three hours after their rounds, the RPN heard sounds coming from the nutrition equipment in resident #007's room, and found that the condition of the resident's nutritional supplement had gone bad, although the nutritional supplement had not expired. The RPN felt the container that the nutritional supplement was in and noted it was warm. The RPN further stated the window and curtains of the resident's room were

opened and that the nutritional supplement was in the sun.

RPN #118 had gone to the SNO for assistance, but they were busy and unable to assist the RPN. RPN then went to Acting ADOC/RN #129, who provided the RPN with the required assistance. The RPN further stated it was their usual process to document an incident like this in the progress notes for next shift, but could not recall if they had done so for this incident, and no notes could be found in the progress notes regarding this incident.

During an interview with Acting ADOC/RN #129, they stated that they recalled the incident when they were called by RPN #118 to provide assistance with resident #007. The Acting ADOC/RN stated that as the RPN had asked for assistance only and no changes were made to the resident's nutritional care, they would not document this, but would expect the RPN to document to notify next shift to monitor the resident.

Interview with RD #154 stated they were not aware of any issues or incidents with resident #007's nutritional supplement. The RD further stated that there had been incidents several years ago related to the condition of residents' nutritional supplements during the summer when the supplements became too hot, and the RD had informed the staff at the time about proper storage and provision of the nutritional supplements to residents to preserve the condition of the supplements provided to residents. The RD stated that the new and agency staff may not have been aware of this issue, and as the RD was not aware of the incident, this information was not communicated to the new and agency staff.

Interview with the acting DOC stated that they would have expected the registered staff to collaborate and communicate with the next shift if any issue was encountered with the resident's nutritional supplements to determine any negative impact on the resident, and to consider referring to the RD to further assess the resident if needed, and this was not done for resident #007. [s. 6. (4) (a)]

5. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. Concerns regarding nutritional

care included: Lack of permanent staff and oversight, feeding status not posted and not readily available, inappropriate meals being served or fed to residents, and PSWs not providing enough time or assistance to residents who require feeding assistance.

Resident #008 was included as part of the resident sample to inspect on the home's nutrition and hydration process for residents.

Review of resident #008's written plan of care at the time of the inspection showed that the resident was to be provided moderately-thickened fluids, and that the resident required feeding assistance.

Mealtime observation by inspector #646 on one unit showed that the beverage cart had one large carton of moderately-thickened water, and one large carton of mildly-thickened juice. No other thickened juices were observed on the cart. Agency PSW #145 was observed to pour the moderately-thickened water into a cup and the mildly-thickened juice into another cup and provided both cups to resident #008. The inspector observed program staff #175 provide the mildly-thickened juice and moderately-thickened water to resident #008. The resident was observed to cough after several spoonfuls of juice, and the program staff stopped feeding the resident to allow the resident to clear their throat.

Interview with agency PSW #145 showed that they had access to the electronic records for residents, but the staff had not checked the records before serving residents their meals, and no dietary binder was on the cart at the point of service.

In an interview, the FSM stated that resident #008 should have received moderately-thickened water and moderately-thickened juice, not mildly-thickened juice. Interview with the FSM stated that the process prior to the outbreak was for special beverages, such as thickened fluids, to be poured out by dietary staff and labeled for specific residents. This process was put on hold during the outbreak, and the PSWs were currently to pour the thickened beverages from the cart for the residents. The FSM clarified that there are no thickeners on the serving carts, but the home has both packaged moderately and mildly thickened water and juices that were to be poured for residents. The FSM stated it is the dietary staff who prepare the juice carts, and the cart should have both moderately-thickened water and moderately-thickened juice for the PSWs to pour. Observation of the dietary storage room showed that moderately thickened water and moderately-thickened juices, and mildly-thickened water and mildly-thickened juices were stocked and available. The FSM stated that the dietary staff preparing the cart may not have looked carefully at the boxes of thickened fluids and did not provide the correct fluids for PSWs

to use on the cart. There was increased risk of swallowing difficulties for resident #008 when they were provided fluids that were not thickened to the level that the resident needed.

Interview with the acting DOC stated that the staff should collaborate to ensure residents receive the diet and fluids as per their plan of care, and this was not done for resident #008 who required moderately-thickened fluids, when the dietary staff placed mildly-thickened rather than moderately-thickened juice on the beverage cart, and the PSW poured mildly-thickened juice for the resident, and the activity staff provided the mildly-thickened juice for resident #008. [s. 6. (4) (b)]

6. Resident #004 was included as part of the resident sample to inspect on the home’s nutrition and hydration process for residents.

Review of resident #004’s electronic written care plan at the time of the inspection showed that the resident was to be provided moderately-thickened fluids with feeding assistance from the staff.

Mealtime observation by inspector #646 showed that the beverage cart had one large carton of moderately-thickened water, and one large carton of mildly-thickened juice. No other thickened juice was observed on the cart. Agency PSW #131 was observed to pour one cup of moderately-thickened water and one cup of mildly-thickened juice, and the PSW brought both cups to resident #004. PSW #131 was observed providing mildly-thickened juice to the resident by holding the cup while the resident took a sip from the cup. No coughing was observed. Agency PSW #131 continued to assist the resident with their meal.

In an interview with PSW #131, they stated that they are aware the resident is to have moderately-thickened fluids, but they did not read the label on the boxes of thickened water and juice from the beverage cart, and was not aware that the juice was mildly-thickened.

In an interview, the FSM stated that resident #004 should have received moderately-thickened water and moderately-thickened juice, not mildly-thickened juice. Interview with the FSM stated that the process prior to the outbreak was for special beverages, such as thickened fluids, to be poured out by dietary staff and labeled for specific residents. This process was put on hold during the outbreak, and the PSWs were currently to pour the thickened beverages from the cart for the residents. The FSM clarified that there are no

thickeners on the serving carts, but the home has both packaged moderately and mildly thickened water and juices that were to be poured for residents. The FSM stated it is the dietary staff who prepare the juice carts, and the cart should have both moderately-thickened water and moderately-thickened juice for the PSWs to pour. Observation of the dietary storage room showed that moderately thickened water and moderately-thickened juices, and mildly-thickened water and mildly-thickened juices were stocked and available. The FSM stated that the dietary staff preparing the cart may not have looked carefully at the boxes of thickened fluids, and did not provide the correct fluids for PSWs to use on the cart. There was increased risk of swallowing difficulties for resident #004 when they were provided fluids that were not thickened to the level that the resident needed.

Interview with the acting DOC stated that the staff should collaborate to ensure residents receive the diet and fluids as per their plan of care, and this was not done for resident #004 who required moderately-thickened fluids, when the dietary staff placed mildly-thickened rather than moderately-thickened juice on the beverage cart, and the PSW poured and provided mildly-thickened juice to resident #004. [s. 6. (4) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the residents' palliative care status, so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The home has failed to ensure that the resident-staff communication response system was easily seen, accessed, and used by residents, staff and visitors at all times.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. The following concerns regarding standards of practice and quality of care concerns were noted by the CAF ACC specifically that residents were observed crying for help with staff not responding for 30 minutes to over two hours.

Resident #006 was included as part of the resident sample to inspect on the home's call bell / communication response system.

Review of the home's alarm history report call bell logs showed that there were no records for the entire LTCH for 23 days between April to May 2020.

Review of resident #006's call bell logs showed the following:
- On a day in May, the call bell alarmed from resident's room for an identified period of time before the call was acknowledged, and the reset button was pressed,
- On another day in May, the call bell alarmed from resident's room for an identified

period of time before the call was acknowledged and the reset button was pressed, and for another hour and a half later in the day before the call was acknowledged, and the reset button was pressed.

Interview with the Environmental Services Manager (ESM) stated that the home had contacted the call bell management company, but the company was unable to retrieve the missing call bell alarm history records for the identified period above. The ESM stated there were no reports from the staff that the call bell system had shut down during this time, and they were not aware of it malfunctioning. They further stated that no other call bell alarm history records were missing outside of the period above.

Interview with the acting DOC stated that the PSWs should be checking residents' call bells on every shift, and report to the maintenance department if the call bells were not working. Interview with ADOC #185 stated that the ADOCs and the ESM have access to the call bell logs, but they were not aware of any process in place for regular review of the call bell logs to check that the call bells were in proper working order.

The ESM stated that the call from the current call bell system goes directly to the pagers that PSWs were to carry on their person. The only way for staff to know which resident activated their call bell is through the call bell pager. However, at the end of April or beginning of May, the ESM had noticed the call bell pagers were turned off and left in the docking stations at the nursing station; the PSWs were not carrying the pagers with them. The ESM had reminded PSWs to carry the pagers with them. The ESM stated they had also informed the acting DOC and ADOCs.

Observation by inspector #646 on the evening shift on one unit, identified three of five pagers were in the docking station, and the two PSWs assigned on the unit did not carry their call bell pagers.

Inspector #646's observation on another day during day shift on the same unit identified that three of the five pagers were in the docking station. Interviews with two PSWs and one RPN working on the unit showed that they did not carry call bell pagers.

Review of resident #006's current care plan showed: Place call bell within resident's reach, check that it is in working order and remind/encourage resident to use it.

Observation of resident #006 by inspector #646 during a day shift showed the resident had tried to activate their call bell three times, but the signal light by the head of the

resident's bed did not light up, and there was no audible sound from the pagers in the hallway. The inspector also tested the call bell by activating it, but the signal light at the head of the resident's bed did not light up. The inspector notified RPN #118 that resident #006's call bell signal light did not turn on when the call bell was tested by the resident and the inspector. The RPN tested the call bell but the signal light at the head of the bed did not turn on, and there was no audible sound from the call bell pagers from the hallway. The RPN unplugged, then reconnected the call bell, pressed the call bell button, and the signalling light at the head of resident #006's bed began to blink. PSW #147 had also come in to resident #006's room to assist the RPN with the call bell, and showed the inspector that the resident's room number showed on their pager when the RPN activated the call bell.

Interview with resident #006 stated that they needed staff assistance for daily care. The resident stated that it is not usually a long wait for someone to answer the call bell, but occasionally, depending on how busy the staff are, it may take longer. The resident recalled an incident where they needed staff attention for personal care and had to wait for a long time, but they could not recall the date of the incident.

In an interview with PSW #147, they stated that resident #006 may have loosened the connection between the call bell and the wall when the resident was pulling on the call bell cord, so that when the resident attempted to activate the call bell, no signal was received. The PSW showed the inspector that resident #006's room and bed number showed up on the call bell pager when the nurse activated the call bell earlier.

Interview with the acting DOC stated that the PSWs and registered staff are expected to answer the call bells in a timely manner. The acting DOC explained that the length of time seen between activation and acknowledgement of call bells on the call bell alarm history reports may be that the staff had responded to the resident but did not cancel the call bell button.

The acting DOC further stated that the home's resident-staff communication response system, which was to be seen, accessed, and used by residents and staff at all times, were the call bell and the call bell pagers. They stated the PSWs and registered staff were expected to carry their call bell pagers so that they would be alerted if residents called for assistance, and that this was not done for resident #006. [s. 17. (1) (a)]

2. Resident #014 was included as part of the resident sample to inspect on the home's call bell / communication response system.

Review of resident #014's current care plan showed: Place call bell within resident's reach, check that it is in working order and remind / encourage to use it.

Review of the home's alarm history report call bell logs showed that there were no records for the entire LTCH for 23 days between April to May 2020.

Review of resident #014's call bell logs showed the following:
- On a day in April 2020 the call bell alarmed from resident #014's room for an identified period of time before the call was acknowledged, and the reset button was pressed.
- On another day in April 2020, the call bell alarmed from the resident's room for an identified period of time before the call was acknowledged, and the reset button was pressed;
- On a day in May 2020, the call bell alarmed from the resident's room for an identified period of time before the call was acknowledged, and the reset button was pressed;
- On a day in May 2020, the call bell alarmed from the resident's room for an identified period of time before the call was acknowledged, and the reset button was pressed.

Resident #014 was not cognitively able to be interviewed.

Inspector #646 tried resident #014's call bell on day shift, and the signal light turned on at the head of resident #014's bed. No staff member came in to the resident's room after the inspector waited for an identified period of time. The inspector observed that seven of ten call bell pagers were left in the docking station for that floor. The call bell pagers were turned off and no sound was heard. After another identified period of time, the inspector observed that resident #014's call bell signal continued to illuminate at the head of the resident's bed. Interviews with PSWs #132, #179, and #180 revealed that all three PSWs on the unit were not carrying call bell pagers.

In an interview with PSW #179, they stated that they didn't carry a call bell pager with them during their shift that day, but showed the inspector where the call bell pagers were. When the PSW turned on one call bell pager, all pagers began to alarm. The PSW showed the inspector that resident #014's room number was displayed on the pager, showing that their call bell had been activated. PSW #179 further stated that resident #014 usually calls out to the staff if they needed assistance.

In an interview, PSW #180, they stated that it was busy on the unit during their shift, and the staff did not carry their call bell pager. However, the PSW acknowledged that it was

the practice for staff to carry call bell pagers to know which resident is asking for help, and whether the resident needed help in their room or in their washroom. The PSW stated the call bell could only be cancelled in the room where the call was activated and could not be cancelled from the pager.

Interview with the acting DOC stated that the PSWs and registered staff are expected to answer the call bells in a timely manner. The acting DOC explained that the length of time seen between activation and acknowledgement of call bells on the call bell alarm history reports may be that the staff had responded to the resident but did not cancel the call bell button.

The acting DOC further stated that the home's resident-staff communication response system, which was to be seen, accessed, and used by residents and staff at all times, were the call bell and the call bell pagers. They stated that PSWs and registered staff were expected to carry their call bell pagers so that they would be alerted if residents called for assistance, and that this was not done for resident #014. [s. 17. (1) (a)]

3. Resident #020 was included as part of the resident sample to inspect on the home's call bell / communication response system.

Review of resident #020's current care plan indicated: Place call bell within resident's reach, check that it is in working order and remind / encourage to use it.

Review of the home's alarm history report call bell logs showed that there were no records for the entire LTCH for 23 days between April to May 2020.

Review of resident #020's call bell logs showed the following:
- On a day in May 2020, the call bell alarmed from resident #020's room for an identified period of time before the call was acknowledged, and the reset button was pressed.

Observation conducted by inspector #764 on day shift showed that seven of ten call bell pagers were observed in the docking station for that floor.

In an interview, resident #020 stated that they noticed many of the staff do not carry their call bell pagers. The resident stated they have noticed some of the residents have to cry out asking for the staff to assist them. The resident further stated that a PSW had told them they couldn't hear the residents' call bells because they were not carrying the pager. The resident could not remember which PSW it was. Resident #020 further stated

that if they needed staff's assistance, instead of using the call bell, they would go directly to the nursing station to call the staff.

Interview with the acting DOC stated that the home's resident-staff communication response system, which was to be seen, accessed, and used by residents and staff at all times, were the call bell and the call bell pagers. They further stated that PSWs and registered staff were expected to carry their call bell pagers so that they would be alerted if residents called for assistance, and that this was not done for resident #020. [s. 17. (1) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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 has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. The following concerns regarding identified altered skin integrity care were noted: Forceful and aggressive resident transfers.

Resident #019 was included as part of the sample to observe transferring of residents in the home. Review of the resident's quarterly assessment showed that resident #019 needed physical assistance and identified transfer equipment for mobility and transfer.

Review home's transfer assessment component guide showed that resident #019 should use an identified size of transfer equipment component. Review of the resident's written plan of care also directed staff to use the same size of transfer equipment component.

Observation of resident #019 by inspector #764, showed that two PSWs used a different transfer equipment component than what was stated in the resident's care plan. PSW #136 stated that all the residents have their own transfer equipment component. The PSW checked the name on the component and saw that the component had another resident's name on it, and the PSW mentioned that it was the only identified component of transfer equipment available in the room and checked it with the regular PSW.

The regular PSW #106 stated that they always used the same transfer equipment component for resident #019's transfers and stated that all transfer equipment components were the same and did not differ in size.

During interview with Staff Education Coordinator, they stated training on the identified transfer component was not a part of general orientation, but there was a section for use of identified transfer equipment in the online learning for all the newly hired PSW and registered staff.

During interview with PSW #136, they stated that they had not received any transfer education or transfer equipment component education at the point of hire but later completed it through online learning.

During interview with RN #103, they stated that they expected the PSWs to check the electronic records and the resident's written plan of care to identify and use the designated transfer equipment component for each resident to promote safe transfers of residents. RN #103 stated that there was no Special Project Nurse (SPN) since the identified outbreak started in the home, who was supposed to follow up to ensure the transfer equipment components were labeled with the correct residents' names.

During interview with the acting DOC, they stated the last audit on transfer equipment and transfer equipment component was done several months ago, and there had been no follow up since. [s. 36.]

2. Resident #007 was included as part of the resident sample as a result of non-compliance found for resident #019 related to transfer and positioning.

Resident #007's quarterly assessment, indicated the resident needed physical assistance and used an identified transfer device to transfer between surfaces.

Review of the home's transfer assessment component guide showed that resident #007

should use an identified size of transfer equipment component. Review of the resident's written plan of care also directed staff to use the same size of transfer equipment component.

Observation of resident #007 by inspector #764, showed that PSW #143 and PSW #180, used a different transfer equipment component that was stated in the resident's plan of care.

During interview with Staff Education Coordinator, they stated training on the identified transfer component was not a part of general orientation, but there was a section for use of identified transfer equipment in the online learning for all the newly hired PSW and registered staff.

During interview with PSW #180 and PSW #143, they stated they had received education on transfer equipment component about a year ago, and they were supposed to check the names on the identified component of transfer equipment to ensure they were using the right one for the residents.

During interview with RN #103, they stated that they expected the PSWs to check the electronic records and the resident's written plan of care to identify and use the designated transfer equipment component for each resident to promote safe transfers of residents. RN #103 stated that there was no SPN since the identified outbreak started in the home, who was supposed to follow up to ensure the transfer equipment components were labeled with the correct residents' names.

During interview with the acting DOC, they stated the last audit on transfer equipment and transfer equipment component was done several months ago, and there had been no follow up since. [s. 36.]

3. Resident #005 was included as part of the resident sample as a result of non-compliance found for resident #019 related to transfer and positioning.

Review of the home's transfer assessment component guide showed that resident #005 should use an identified size of transfer equipment component. Review of the resident's written plan of care stated the resident required assistance with transfer, and also directed staff to use the same size of transfer equipment component.

Observation by inspector #646 showed that PSWs #131 and #147 had used and

identified transfer component that was different than what was stated in resident #005's written plan of care to transfer the resident.

During interview with PSW #147, they stated there was a binder which clarified which transfer equipment component sizes were to be used for each resident who required it. However, upon reviewing the binder with the inspector, the PSW stated that the documents with residents' transfer equipment component size was missing from the binder.

During interview with Staff Education Coordinator, they stated training on the identified transfer component was not a part of general orientation, but there was a section for use of identified transfer equipment in the online learning for all the newly hired PSW and registered staff.

During interview with RN #103, they stated that they expected the PSWs to check the electronic records and the resident's written plan of care to identify and use the designated transfer equipment component for each resident to promote safe transfers of residents. RN #103 stated that there was no SPN since the identified outbreak started in the home, who was supposed to follow up to ensure the transfer equipment components were labeled with the correct residents' names.

During interview with the acting DOC, they stated the last audit on transfer equipment and transfer equipment component was done several months ago, and there had been no follow up since. [s. 36.]

4. Resident #028 was included as part of the resident sample as a result of non-compliance found for resident #019 related to transfer and positioning.

Review of resident #028's most recent quarterly assessment showed that the resident required assistance and identified transfer equipment for transfer.

Review of the home's transfer assessment component guide showed that resident #028 should use an identified size of transfer equipment component. Review of the resident's written plan of care directed staff to use an identified transfer equipment with two staff, and also directed staff to use the same size of transfer equipment component.

Inspector #764's observation of PSW #127 showed that they did not use the identified transfer equipment to transfer the resident. The PSW explained to the inspector that the

resident was able to transfer from bed to chair by themselves and needed only one-person assistance to transfer, but they required the use of a transfer equipment for transfer from chair to bed. PSW #127 showed the inspector that resident had two transfer equipment components. However, both of these transfer components were different from the size than what was stated in resident #028's written plan of care.

During interview with Staff Education Coordinator, they stated training on the identified transfer component was not a part of general orientation, but there was a section for use of identified transfer equipment in the online learning for all the newly hired PSW and registered staff.

During interview with PSW #127, they stated that they had worked with the same residents for about a year and knows the residents, but if they were working with a new resident, they would check the resident's plan of care.

During interview with RN #103, they stated that they expected the PSWs to check the electronic records and the resident's written plan of care to identify and use the designated transfer equipment component for each resident to promote safe transfers of residents. RN #103 stated that there was no SPN since the identified outbreak started in the home, who was supposed to follow up to ensure the transfer equipment components were labeled with the correct residents' names.

During interview with the acting DOC, they stated the last audit on transfer equipment and transfer equipment component was done a several months ago, and there had been no follow up since. [s. 36.]

5. Resident #031 was included as part of the resident sample as a result of non-compliance found for resident #019 related to transfer and positioning.

Review of resident #031's quarterly assessment, showed that the resident was totally dependent for mobility and transfer, and required physical assistance and use of an identified transfer equipment.

Review of the home's transfer assessment component guide showed that resident #005 should use an identified size of transfer equipment component. Review of the resident's written plan of care stated the resident required two staff assistance with transfer, using an identified transfer equipment, and also directed staff to use the same size of transfer equipment component as the guide assessed.

Observation of resident #031 by inspector #764, showed that the staff had completed the transfer for the resident from bed to wheelchair. The inspector observed that two PSWs were in the room, and PSW #127 was holding a transfer equipment component that was different than what was stated in resident #031's written plan of care.

During interview with Staff Education Coordinator, they stated training on the identified transfer component was not a part of general orientation, but there was a section for use of identified transfer equipment in the online learning for all the newly hired PSW and registered staff.

During interview with PSW #139, they stated they did not receive any education from the home on the use of transfer equipment and transfer equipment component but learned it from other PSWs working in the unit. They stated to ensure that they were using the right identified component of transfer equipment for the resident, they would check if the resident's name was on it.

During interview with PSW #127, they stated had worked in the same assignment for over a year, with the same residents and know them; but if working with a new resident, they will check the care plan.

During interview with RN #103, they stated that they expected the PSWs to check the electronic records and the resident's written plan of care to identify and use the designated transfer equipment component for each resident to promote safe transfers of residents. RN #103 stated that there was no SPN since the identified outbreak started in the home, who was supposed to follow up to ensure the transfer equipment components were labeled with the correct residents' names.

During interview with the acting DOC, they stated the last audit on transfer equipment and transfer equipment component was done several months ago, and there had been no follow up since. [s. 36.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #001, #002, #003, and #018 with identified altered skin integrity, received immediate treatment and interventions to promote healing, and prevent infection, as required.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. The following concern regarding identified altered skin integrity care were noted: Increased number and complexity of identified altered skin integrity.

Review of resident #001's care plan, indicated that the resident was to receive treatment to an area of altered skin integrity, monitoring, weekly assessment, positioning, and

nutritional supplement. It showed the resident required extensive assistance and physical assist for bed mobility.

Review of an altered skin integrity risk assessment showed that resident #001 was at high risk for developing altered skin integrity.

Review of resident #001's progress notes showed that the resident had a new area of altered skin integrity on an identified date. Over the next 30 days, there was identified deterioration of resident #031's altered area of skin integrity. At the end of the 30 days, when the resident was found with new and additional symptoms, they were transferred to the hospital.

Review of the resident's quarterly assessment showed that the resident had a worsening altered skin integrity at 27 days after it was first identified.

During interview with RPN #108, they stated that, resident #001's area had worsened since their first follow up assessment, nine days after it was first identified.

Review of the resident's identified altered skin integrity assessment history indicated that the resident's area was assessed nine days after it was first identified, then continued to worsen in the next three assessments.

Review of the resident's area dressing orders showed that although the area had worsened over the month, no changes were made to the treatment orders.

During interview with RPN #108, they stated that during the identified disease outbreak, they were assigned to work on different units as RPN and in addition to being in charge of completing residents' altered skin integrity assessments. They stated that prior to the outbreak, resident #001 did not have the altered area of skin integrity.

During interview with EES, they stated that skin and area training was included in the general orientation for staff under the online learning.

During separate interviews with acting ADOC #129 and RPN #108, they stated the PSWs had received specific education regarding skin care and application of therapeutic barrier cream.

Observation by inspector #764 showed that the skin and altered skin integrity care

binder, including the altered skin integrity care protocols, skin and altered skin integrity orientation checklist, skin and altered skin integrity framework, instruction regarding digital assessment and reporting of new skin integrity impairment form were available on all units.

During an interview, PSW #115 stated that they would report any changes in residents' skin integrity condition to the nurses and that the PSWs would correctly apply the barrier treatment cream for residents to prevent the skin breakdown.

Observation by inspector #764 showed that PSW #127 had reported their assigned residents' skin conditions to RPN #126.

During separate interviews with RPNs #112, #118, #126 and #117, they stated upon PSWs' report of any new or worsened skin integrity condition, they would follow the skin and area protocols, start the assessment process by taking the digital pictures, enter the assessment information and send referrals to the skin and area lead, RD and inform the Substitute Decision Maker (SDM). They stated the skin and wound care lead would consult with physician, manage the treatment orders and coordinate the weekly skin and area assessment.

During interview with the skin and area lead (RPN #108), they stated that an identified altered skin integrity assessment should be done upon discovery of a new identified altered skin integrity or a change in the identified altered skin integrity condition. This was not done for resident #001 based on assessment data, when the identified altered skin integrity had subsequently deteriorated. [s. 50. (2) (b) (ii)]

2. Resident #002 was included as part of the resident sample as a result of non-compliance found for resident #001 related to skin and identified altered skin integrity care.

Review of resident #002's progress notes showed that on identified date, an altered area of skin integrity was identified for the resident.
- A wound assessment for the resident the next day identified the resident had an area of altered skin integrity.
- A note seven days later showed an RD referral was completed.
- Ten days later, the resident was sent to the hospital related to an identified infection.

During interview with the skin and area lead (RPN #108), they indicated that the first time

the resident's identified altered skin integrity was recorded that it was already progressing and there were no treatment or interventions in place to prevent deterioration. Interviews with the skin and area lead, two other RPNs and one RN, further stated that if the PSWs reported any skin and area issues to the nurse, the resident would be assessed, picture would be taken, referrals sent to the RD and the skin and area lead, and treatment would be started per identified altered skin integrity protocol. [s. 50. (2) (b) (ii)]

3. Resident #003 was included as part of the resident sample related to non-compliance found for resident #001 related to skin and identified altered skin integrity care.

Review of resident #003's progress notes showed that the resident had an altered skin integrity.
- Documentation on the next day showed it had worsened.
- The initial assessment was done 13 days after the area was first identified.
- Review of the resident's identified skin and area assessments showed that the next three weekly area assessments were completed on time.

The resident's quarterly assessment, completed 21 days after it was identified, showed that the altered skin integrity had deteriorated.

During interview with RPN #108, they stated although the first report of the identified altered skin integrity was recorded, no assessment was done for resident #003 and the first identified altered skin integrity assessment was done on two weeks later. They stated if the nurses did not take a picture and send the referral, they will not be aware of the identified altered skin integrity. They further stated that if the PSWs reported any skin and identified altered skin integrity issue to the nurse, the identified altered skin integrity was assessed, picture was taken, referrals were sent to the RD and identified altered skin integrity care lead and treatment would be started per identified altered skin integrity protocol. [s. 50. (2) (b) (ii)]

4. Resident #018 was included as part of the resident sample as a result of non-compliance found for resident #001.

Review of the resident #018's progress notes recorded the first report of an identified altered skin integrity.

During interview with RPN #108, they stated that resident #018 was independent with

bed mobility. RPN #108 stated that the deterioration of the resident's altered skin integrity was not captured before it had progressed and agreed that an identified altered skin integrity assessment was needed for any new identified altered skin integrity and any change in identified altered skin integrity condition. They added that the PSWs had provided the continence care and changed the resident daily and didn't report the altered skin integrity although they had received training and education. RPN #108 further stated that if the PSWs had reported any skin and identified altered skin integrity issue to the nurse, the area would be assessed, pictures would be taken, and referrals would be sent to the RD and the skin and wound care lead and the treatment would be started per identified altered skin integrity protocol. [s. 50. (2) (b) (ii)]

5. The licensee has failed to ensure that residents #001, #002, and #003, who exhibited altered skin integrity, were assessed by the registered dietitian.

Review of skin risk assessment and head-to-toe skin assessment in resident care and services manual (RCS G-35-05, last revised date: July 29, 2019) indicated: The skin care coordinator and registered dietitian should be notified when a resident is exhibiting altered skin integrity (this includes skin tears, bruises, identified altered skin integrity and any other identified altered skin integrity or skin breakdown), the Substitute Decision Maker (SDM) and physician.

Review of the home's identified altered skin integrity care protocol indicated RD referral should be sent for at an identified skin integrity at identified stage or any deep tissue injury.

Review of the home's skin and identified altered skin integrity framework indicated: RD referral is required for skin tear, pressure injury, blister, cancer lesion, laceration, open lesion, surgical identified altered skin integrity and venous identified altered skin integrity.

Review of the home's quick reference guide for skin and identified altered skin integrity, indicated that an RD referral should be sent for skin tears and all other skin related injuries.

Review of skin and identified altered skin integrity orientation checklist for registered staff, indicated to send an electronic RD referral as a part of documentation for newly discovered identified altered skin integrity and/or skin impairment: pressure injuries, venous ulcers, arterial ulcers, diabetic ulcers, palliative ulcers, skin tears, rashes, and bruises etc.

Based on Braden Scale for Predicting Pressure Sore Risk, showed that resident #001 was at high risk for developing identified altered skin integrity.

Review of resident #001's progress notes showed that the resident had a new area on an identified date. Over the next 30 days, there was identified deterioration of resident #031's altered area of skin integrity. At the end of the 30 days, when the resident was found with new and additional symptoms, they were transferred to the hospital.

Review of the resident's quarterly assessment indicated that the resident had an altered skin integrity.

Review of the PCC dashboard showed that RD #207 noted a decline in referrals for residents in the home.

During interview with RD #198, they stated that nurses should send the RD referrals for any type of skin integrity impairment except bruise, rash, pimples and abrasion and they noticed during identified disease outbreak, they were not receiving referrals.

During interviews with RPN #108, RPNs #118 and #128, and RN #103, they stated that there was a skin and identified altered skin integrity binder where all the units have access to identified altered skin integrity care protocols and guidelines, and they were aware that RD referrals should be sent upon any new or change in skin condition.

During interview with the RPN #108, they stated based on progress notes, the identified altered skin integrity was recorded and the condition has changed. RPN #108 stated an RD referral needed to be sent whenever there was a new identified altered skin integrity or a change in the identified altered skin integrity condition. For resident #001 an RD referral was not sent when the resident's skin condition changed. [s. 50. (2) (b) (iii)]

6. Resident #002 was included as part of the resident sample as a result of non-compliance found for resident #001.

Review of resident #002's progress notes showed that a skin breakdown was recorded for the resident on an identified date. On the next day, the altered skin integrity was assessed to be at a deteriorated condition. At the end of a 30-day period, the altered skin integrity continued to be at the same deteriorated condition.

Interviews with RPN #118, RN #103 and RPN #128 confirmed that an RD referral should be sent upon any change in the resident's skin condition.

During interview with RD #198, they stated nurses should send the RD referrals for any type of skin integrity impairment except bruise, rash, pimples and abrasion, and they noticed that they were not receiving these referrals during the outbreak.

During interview with RPN #108, they stated a referral should be sent to the RD whenever there was a new identified altered skin integrity or a change in the identified altered skin integrity condition, and for resident #002, an RD referral was not sent until the area had further deteriorated. [s. 50. (2) (b) (iii)]

7. Resident #003 was included as part of the resident sample as a result of non-compliance found for resident #001.

Review of the resident #003's progress notes showed that the resident had an altered area of skin integrity on an identified date.
- Documentation on the next day showed that the area had worsened.
- The initial area assessment was done 13 days after it was first identified.
- The RD referral sent 15 days after it was first identified, and the RD assessment was completed on the same day.

During interview with RD #198, they stated nurses should send the RD referrals for any type of skin integrity impairment except bruise, rash, pimples and abrasion and they noticed during the outbreak, they were not receiving these referrals.

Interview with RPN #108 stated, a referral should be sent to the RD whenever there was a new identified altered skin integrity or a change in the identified altered skin integrity condition, and for resident #003, no RD referral was sent when the new identified altered skin integrity was noted. [s. 50. (2) (b) (iii)]

8. The licensee has failed to ensure that residents #011 and #033, who were dependent on staff for repositioning, were turned and repositioned every two hours.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. The following concern regarding identified altered skin integrity care was noted: No turning or repositioning of residents.

Resident #033 was included as part of the resident sample to inspect on the home's palliative care program.

Review of resident #033's quarterly assessment showed they required assistance to move to and from a lying position, turn from side to side, and for staff to position the resident's body while they were in bed.

Review of progress note between over a six-month period showed three documentations of turning and repositioning for the resident.

Review of the resident's written plan of care stated staff were to turn and reposition the resident every two hours and as needed, monitor for moaning, facial grimacing, guarding, rigidity and obvious discomfort, and to notify the registered staff immediately if concerns are noted.

On three different dates and various times throughout the day, observations made by inspector #764 identified the resident was not repositioned.
During interview with RN #103, they stated resident #033 required repositioning every two hours as indicated as a task in the electronic documentation for PSWs.

During interview with EES #153, they stated turning and reposition is a part of skin and identified altered skin integrity care online learning in staff general orientation.

During interview with PSW #102, they stated they did it in the morning once for resident #033 and not again. They mentioned that resident #033 wanted to be on their back in the bed whenever PSW #102 offered to change the position.

During interview with PSW #139 on identified date, two hours after starting the shift, they stated they usually turned resident #033 three times per shift, but they hadn't repositioned the resident at all as they were busy serving the snacks.

During interview with RN #103, they stated that for resident #033 turning and repositioning every two hours. The directions in the care plan should be followed by PSW staff. Observations by inspector #764 on identified dates, showed that the resident was not turned and repositioned.

During interview with RPN #108, they stated they expected PSWs to follow the directions in the POC task and turn and reposition resident #033 every two hours. They stated that

based on inspector #764's observations mentioned above, turning and repositioning for resident #033 was not done. [s. 50. (2) (d)]

9. Resident #011 was included as part of the resident sample related to non-compliance found for resident #033 related to turning and repositioning of residents.

Review of resident #011's RAI-MDS assessment, showed that resident #011 was totally dependent and required two persons physical assist for bed mobility.

Review of progress notes indicated resident #011 to be turned to prevent further skin break down.

Review of plan of care indicated turn, reposition at least every two hours, more often as needed or requested and observe resident pressure points.

On two different dates and various times throughout the day, observations made by inspector #764 identified the resident was not repositioned.

During an interview with PSW #144, they stated that resident #011 had to be repositioned every two hours but they didn't want to interfere with care the resident was to receive, so repositioning was not done for resident #011 as per the care plan.

During interview with PSW #145, they stated that they did not receive any instruction regarding turning and positioning of the resident, but they did provide assistance to the resident twice during their shift; although they were not the primary PSW assigned to the resident.

During interview with RPN #108, they stated they expected the PSWs to follow the POC, and to turn and reposition resident #011 every two hours, and that if the resident was turned and repositioned, they would not be observed to be in the same position for entire shift by the inspector. They further stated that, based on the inspector #764 observations above, turning and repositioning for resident #011 was not done. [s. 50. (2) (d)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 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 the staff participated in the implementation of the infection prevention and control program.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. The following concerns regarding infection prevention and control were noted: lack of training and adherence to Infection Prevention and Control (IPAC) protocols, and staff not changing Personal Protective Equipment (PPE) for several hours while moving between numerous resident rooms.

No concerns were identified related to the frequency of donning and doffing practices of registered staff and PSWs in the home during the period of onsite inspection.

The following IPAC concerns were observed by inspectors during the inspection:

I. PPE USE
A) On a day in May 2020, on one unit, a regular PSW was observed to don their reusable gown by tying a knot at the neck prior to wearing the gown and pulled the hole of the knotted gown over their head, while their mask and face shield remained on during this process. The PSW was observed to remove their gown by loosening the knot at the neck and pulling the gown off over their head. In an interview with the PSW, they stated that this was a practice they learned in school.

B) On another day in May 2020, on another unit, an agency PSW was observed to be wearing a face shield and two masks while providing care for residents on the unit. When donning a new gown, the PSW was observed to tie the neck strap of the gown prior to putting the gown on, making a hole for the head, and the PSW slid the pre-tied gown over their head and face shield. The neck area of the gown had contacted and wiped the

front of the face shield, which had been worn in various residents' rooms, as the PSW donned their gown. The PSW's face shield was not observed to be cleaned or disinfected between residents.

In an interview with the PSW, they stated that they had received orientation and training when they were hired. The PSW said that their method of donning gowns by tying a knot prior to wearing the gown was a method they had learned in school. They further stated that they would use this method of donning while keeping their mask and face shield on. The PSW further stated that it was their own practice to wear two masks, and they would take the outer mask off and keep the inner mask on if they need to change it.
Review of the staff orientation sign-in sheet showed the agency PSW had received Orientation, which included multiple IPAC components, including proper donning and doffing of PPE.

C) On another day in May 2020, on another unit, a regular PSW was observed by inspector #646 to walk from the nursing station and entered a resident's room while holding a container in their hands without a mask on their face. The PSW exited the room holding the container several minutes later. The PSW told the inspector that they are not wearing their mask because they had just finished their own meal and was washing their meal container. The staff had washed their meal container in the resident's room.

Interview with the PSW stated that they had received SURGE (online) training and in service in the home related to infection prevention and control practices every year. Review of the PSW online learning records showed their last IPAC training in 2020, and had also completed additional training on PPE donning and doffing.

D) On another day in May 2020, on another unit, an agency PSW was observed to wear two masks while preparing the servery cart with meals for residents. The PSW stated they would take the outer mask off and keep the inner mask on if they need to change their mask.

Review of the staff orientation sign in sheets did not show records for agency PSW #170 when they were first hired, but review of the SURGE training records showed that PSW #170 received their SURGE orientation and onboarding training about two months after they were hired.

Interview with the Employee Engagement Specialist (EES) indicated that they had provided Rapid Onboarding training to the staff members for two agencies, but had not

facilitated the training for the staff hired through the other agencies outside of those two.

In an interview, the Staff Education Coordinator stated that prior to the outbreak, the staff in the home received IPAC training in the fall of 2019, which included hand hygiene, cleaning and disinfection, and policy of cleaning and disinfecting equipment. Additional training was added at the start of 2020 on how to use PPE, and on donning and doffing. The Staff Education Coordinator was away from the home for about one month between April and May 2020, and the EES had helped with training and orientation of staff while they were away. However, the online SURGE training had not been provided for new staff during the period when they were away.

In an interview, the home's Toronto Public Health / Communicable Diseases Investigator (CDI) stated that the recommended practice for donning is to do hand hygiene before putting the gown on, then put on the gown, the face mask, then eye protection as needed. Further, it would not be optimal to slide the gown over the used face shield or face mask, as the staff may be at risk of contamination. The CDI further stated that Toronto Public Health had not recommended for staff to wear double masks, as this was improper use of PPE and may increase risk of transmission of the disease, especially if staff were to remove one mask and not the other.

II. MEAL SERVICE

Observation of breakfast by inspector #646 showed that a PSW poured a hot beverage from the shared carafe into one resident's personal cup that the resident brought out of their room. The same carafe was observed to be used to pour a hot beverage into the disposable cups for other residents on the unit.

The PSW was also observed to pour juice from the open pitcher into another resident's personal container that the resident had brought out of their room. The same pitcher of juice was observed to be used to pour juice into disposable cups for other residents on the unit.

Separate interviews with the acting DOC and the ED, stated that there is a process for cleaning residents' personal items for use during meals by the dietary staff; however, during the outbreak, staff should not be providing food and beverages using residents' personal items. The acting DOC further stated that if residents' personal containers are to be used for meal service, there should to be a process for cleaning the items. Further,

specific directions would need to be put in those residents' care plans. The acting DOC stated this practice was not in place during the outbreak. The acting DOC further stated that the PSW should not have provided the hot beverage and juice into the two residents' personal beverage containers.

In an interview, the acting DOC stated that the staff were expected to follow the home's IPAC program and directions, and in the incidents mentioned above, the staff members did not do so. [s. 229. (4)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee has failed to ensure that there was a process to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs and preferences.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. Concerns regarding nutritional care included: Lack of permanent staff and oversight, feeding status not posted and not readily available, inappropriate meals being served or fed to residents, and PSWs not providing enough time or assistance to residents who require feeding assistance.

Interview with the CAF SNO stated that there were concerns during meal service in the home. They stated that all residents received meals in their own rooms during the outbreak in the home, but some of the staff were ordering meals based or diet textures rather than calling out specific residents' names when ordering meals from the dietary aides. Further, not all PSWs were writing down the residents' names or room numbers on the meal boxes, and residents' diets, special needs or preferences were not always followed when generic meal boxes were provided for residents.

Mealtime observations were conducted over six days on all three floors by inspectors #646 and #764. No concerns were observed regarding mealtime assistance provided for residents, and no forceful feeding or hydration were observed. Interviews with multiple residents regarding mealtime assistance received did not raise any concerns or findings of non-compliance.

Meal service observations showed that the PSWs serving the meals did not refer to any dietary binders or computer tablets for residents' dietary information while serving meals to residents.

Interviews with CAF ACC staff, two agency PSWs, and two of the home's PSWs, they stated that the PSWs could refer to the diet sheets outside residents' rooms when serving meals to the residents. However, during mealtime observations above, the inspectors did not observe any PSWs referring to the diet sheets outside residents' rooms.

Observation of the servery on each floor showed that dietary aides had binders to refer to while portioning the meals into meal boxes, but the dietary aides did not leave the servery and were not present at point of service.

During dinner observation on one unit, meal boxes were observed to be labeled with the choice of entrée being served, but residents' names or room numbers were not written on the boxes. The staff serving the meals were not observed to reference any tablets, computers, or binders when serving meals to the residents. Interview with two PSWs on the first floor stated that the PSWs had not seen or used the dietary binders since the

outbreak, but that the PSWs can refer to the computer at the nursing station for the residents' Kardex if they had any questions.

Dinner observation on another unit showed that the PSW who ordered the meals did not order the meals by resident's name or resident's meal choice. Rather, the PSW requested specific numbers of each diet texture for each of the two meal choices, and wrote 'R' for regular texture, 'M' for minced and 'P' for pureed meal boxes. No residents' names or room numbers were written on the meal boxes. No servery binder or tablet were seen on the cart. When the entrees were provided to residents on the unit by the PSWs, no dietary binder was used, no diet sheet was referenced, and no tablet was used during point of service to the residents.

Breakfast observation on another day showed the residents' room numbers were written on the meal boxes. An agency PSW was observed serving beverages to residents. The agency PSW was observed serving a beverage to a resident, who took one sip of the beverage. Another agency PSW then told the first agency PSW to take away the beverage from the resident, as the resident was allergic to that beverage. The first agency PSW took away from the resident and provided them with an alternative beverage instead. The first agency PSW also offered another resident a beverage, and the resident informed the same PSW that they were allergic to the beverage the PSW was offering.

Interview with the first agency PSW showed that they were new on the unit, and they did not have access to the electronic system to view residents' care plans. The PSW further stated that when they needed information on residents, they would ask the regular PSW, or a more experienced agency PSW.

Interview with a dietary aide stated that the dietary staff currently used the diet book in the servery, as the computer was slow and internet was unreliable. The PSWs were to tell the dietary aides each resident's name and room number when they were serving, and the PSWs should write the residents' room numbers on the meal boxes. Observations of the meal order and packaging process on two days in the servery showed that the described process did not occur. Additionally, one PSW was observed to request diet textures from the dietary aide without calling residents' names, and wrote

diet textures on the meal boxes, with no names or room numbers.

Interview with another dietary aide on another floor showed that the dietary staff had to use paper diet list which was printed by the Food Service Supervisor (FSS) on a day in April 2020, until a new list was printed on a day in May 2020. Interview with the FSM showed that the updating of the paper diet list was not done during a 14-day period, when both the FSS and FSM were away from the home. During this period, if there were any changes to the residents' diet, the nurses would inform the dietary aides and the dietary aide would write on the paper diet list. The dietary aide stated the PSWs would tell the dietary aide how many residents requested each choice and what texture, and the dietary aide would write down the room number and diet texture on the box for the resident.

Interview with both RDs stated that they had not been onsite in the home since the end of March, but had been communicating with the home's staff remotely for any updates and referrals for residents.

During interview, the FSM indicated that the current process for meal service and delivery should be that residents' allergies and preferences be updated in residents care plans and Kardex, and the dietary binders. It should be the dietary staff and not the PSWs to record residents' diets on the meal boxes. Interview with the FSS stated that the PSWs were to let the dietary aides know the residents' meal choices, and the PSWs would reference the diet binders in the servery. The PSWs were also expected to have diet binders on the cart when they were providing meals to residents on the unit, so they were aware of what the residents' diets and preferences were. Further, the diet sheets did not include all the information on residents' diets, special needs, and preferences, and both the FSS and the FSM stated the diet lists posted on residents' doors were not from dietary and they were uncertain who were updating the diet sheets. Without the process to ensure that food service workers and PSWs and staff assisting residents were aware of the residents' diets, special needs, and preferences, there was increased risks for residents to receive an incorrect diet.

One RD stated that the dietary binders should be updated by the FSS or FSM, and available for the dietary staff and other staff who are providing meals and assisting

residents to be aware of their diets, special needs and preferences. Further, the dietary binders and written care plans with residents' diets, special needs, and preferences were not regularly used by PSWs or others serving and assisting residents since the start of the outbreak until about two months later, to ensure that other staff assisting residents were aware of the residents' diets, special needs and preferences. [s. 73. (1) 5.]

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 has a dining and snack service that includes, at a minimum, a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences, to be implemented voluntarily.

Issued on this 17th day of September, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	IVY LAM (646), NAZILA AFGHANI (764)
Inspection No. / No de l'inspection :	2020_769646_0009
Log No. / No de registre :	010545-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 26, 2020
Licensee / Titulaire de permis :	Rykka Care Centres LP 3760 14th Avenue, Suite 402, MARKHAM, ON, L3R-3T7
LTC Home / Foyer de SLD :	Hawthorne Place Care Centre 2045 Finch Avenue West, NORTH YORK, ON, M3N-1M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gale Coburn

To Rykka Care Centres LP, you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007 S.O. 2007, c.8, s. 6. (4).

Specifically, the licensee shall ensure that:

1) Residents #003, #004, and #008, receive an updated dietary assessment from the registered dietitian(s), to ensure the diet texture and fluid consistency is appropriate for the resident, and that this is communicated to the registered staff and PSWs who work with the residents.

2) Residents #003, #004, and #008, are provided the appropriate diet texture and fluid consistency as per the residents' care plans.

3) Resident #007 and all other residents who receive nutritional supplement in the home receive an updated dietary assessment from the registered dietitian(s), to ensure that their prescribed nutritional supplement meets their nutritional needs and is provided to them, and that the assessment results are communicated to the registered staff and PSWs who work with the residents.

4) Food Service Manager, Food Service Supervisor, Registered Dietitian(s), Director of Care, Assistant Directors of Care, and appropriate registered staff members meet to determine strategies for storage and provision of nutritional supplement to minimize the risk of change in consistency, and communicate the decision to the dietary staff and registered staff.

5) A record for actions taken with items #1, #3, and #4, is kept: including the date it was performed, the names of staff who attended, the content of discussion, issues identified and the follow-up actions taken.

6) An audit for item #2 is kept, including the date of the audit, the names of the residents, any issues identified, and resolution provided.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. Concerns regarding nutritional care included: Lack of permanent staff and oversight, feeding status not posted and not readily available, inappropriate meals being served or fed to residents, and PSWs not providing enough time or assistance to residents who require feeding assistance.

In an interview, CAF SNO #107 specified that they had observed force-feeding or force-hydration of resident #013 who required thickened fluids was fed too quickly by RPN #177, and the SNO had asked the RPN to stop and took over feeding for the resident. The SNO was unable to specify the date of the incident. The SNO stated that other CAF staff had also observed force-feeding by other staff members. However, the SNO was unable to provide the names of the staff or residents. The SNO also stated that the home's staff were not always aware of what diets to provide for residents.

At the time of the inspection, resident #013 was no longer in the home. Further, RPN #177 was also no longer employed by the home.

Interviews with two RPNs who worked regularly on resident #013's floor stated that they were unaware of any incidents of force-feeding or force-hydration of residents by RPN #177. Interviews with two PSWs who worked regularly in the home during the months of April and May stated that they had neither observed nor were aware of any incidents of force feeding or force hydration of residents. Separate interviews with the Executive Director (ED) and acting DOC stated that neither the CAF staff nor any of the home staff had informed them of any incidents of force-feeding or force-hydration from staff to resident #013 or any other residents.

Interview with the ED specified that the dining rooms were not used during the outbreak beginning on a day in April 2020 and residents received meal service in their rooms. Interview with the Food Service Manager (FSM) specified that at the start of the meal service, PSWs should tell the Dietary Aides (DAs) the resident's name and choice preference, and the DAs should verify the resident, their diet, texture, allergies and preferences, then put the meal into a box labeled for the specific resident.

Resident #003 was included as part of the resident sample to inspect on the home's nutrition and hydration process for residents.

Review of resident #003's care plan on PCC at the time of the inspection showed resident #003 was to receive a regular diet with a modified diet texture and thickened fluids. Review of the progress notes showed on a day in May, RD #154 had temporarily downgraded resident #003's diet from regular texture to modified texture due to the resident's decline in status. On a later date in May, the RD further downgraded the resident's diet due to their continued decline, and had changed the resident's fluid consistency to thickened fluids on this date.

Observation of breakfast on a day in June 2020 showed that resident #003 was provided a less modified diet and thin fluids – both of which were different than what was in their current written plan of care.

Resident #003 was not cognitively able to be interviewed.

In an interview, PSW #194, who works regularly with resident #003, stated that the resident had been receiving the less modified diet texture and thin fluids for about one week. The PSW further stated that the resident's health status improved since earlier in May 2020, and the PSW had changed resident's diet to a less modified diet with thin fluids to encourage the resident's food intake. The PSW stated they had informed an agency RPN that resident #003 should be upgraded to a less modified texture as the resident's health status had improved and was not eating very much from the more modified diet texture. The PSW stated they thought the nurse would refer to the RD. The PSW did not know if the nurse had followed up with the RD. The PSW stated they had not used the Kardex, care plan, or dietary binder when ordering or serving the resident.

Interview with RD #154, stated that the registered staff whom the PSW had informed regarding resident #003's poor intake with the modified diet texture should have referred to the RD for an assessment, and the PSW should not have provided resident #003 with an upgraded diet different from what was in the resident's care plan without the RD's assessment and recommendation or order. Resident #003 was at increased risk of not being able to tolerate their diet when the nursing staff changed the resident's diet without referral or

collaboration with the RD for a nutrition assessment of the resident.

Interview with the acting DOC stated that the nursing and dietary staff should collaborate to ensure that residents receive the diet and fluids as per their plan of care. The acting DOC further stated that this was not done for resident #003, when the staff upgraded resident #003's diet and provided it to the resident for one week without an RD's assessment and order. (646)

2. This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. Multiple concerns were raised by the CAF in the letter above, including the delivery and condition of nutritional supplements for residents who require nutritional supplements.

Interview with CAF SNO clarified that the incident had occurred only once and was for resident #007. The SNO was notified by RPN #118 in May 2020 regarding an issue with the condition of the nutritional supplement that resident #007 was given, and they were concerned that the supplement had expired.

Review of resident #007's progress notes and eMAR for the months of April and May 2020 did not show any documentation regarding issues with the resident's nutritional supplement and no nutrition/dietary referrals were made related to the nutritional supplements.

Observation of resident #007 by inspector #646 showed that the resident was provided their nutritional supplement at the amount as per their dietary care plan, and the supplement had not expired. No concern regarding the condition of the nutritional supplement was noted. A second observation of resident #007 on a later date showed that the resident was provided the right amount of the right nutritional supplement, and no concerns were noted regarding the condition of the nutritional supplement.

Three other residents who received nutritional supplements in the home were observed on two separate days, and no concerns were noted regarding the delivery or condition of their nutritional supplements.

The nutritional supplements in the storage room were inspected over two days,

and none of the nutritional supplements in the storage were observed to be expired. Multiple types of nutritional supplements were also observed.

In an interview, RPN #118 stated that on the day of the incident, no concerns were noted when the RPN began their shift or did their rounds about one hour later. However, about three hours after their rounds, the RPN heard sounds coming from the nutrition equipment in resident #007's room, and found that the condition of the resident's nutritional supplement had gone bad, although the nutritional supplement had not expired. The RPN felt the container that the nutritional supplement was in and noted it was warm. The RPN further stated the window and curtains of the resident's room were opened and that the nutritional supplement was in the sun.

RPN #118 had gone to the SNO for assistance, but they were busy and unable to assist the RPN. RPN then went to Acting ADOC/RN #129, who provided the RPN with the required assistance. The RPN further stated it was their usual process to document an incident like this in the progress notes for next shift, but could not recall if they had done so for this incident, and no notes could be found in the progress notes regarding this incident.

During an interview with Acting ADOC/RN #129, they stated that they recalled the incident when they were called by RPN #118 to provide assistance with resident #007. The Acting ADOC/RN stated that as the RPN had asked for assistance only and no changes were made to the resident's nutritional care, they would not document this, but would expect the RPN to document to notify next shift to monitor the resident.

Interview with RD #154 stated they were not aware of any issues or incidents with resident #007's nutritional supplement. The RD further stated that there had been incidents several years ago related to the condition of residents' nutritional supplements during the summer when the supplements became too hot, and the RD had informed the staff at the time about proper storage and provision of the nutritional supplements to residents to preserve the condition of the supplements provided to residents. The RD stated that the new and agency staff may not have been aware of this issue, and as the RD was not aware of the incident, this information was not communicated to the new and agency staff.

Interview with the acting DOC stated that they would have expected the registered staff to collaborate and communicate with the next shift if any issue was encountered with the resident's nutritional supplements to determine any negative impact on the resident, and to consider referring to the RD to further assess the resident if needed, and this was not done for resident #007. (646)

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. Concerns regarding nutritional care included: Lack of permanent staff and oversight, feeding status not posted and not readily available, inappropriate meals being served or fed to residents, and PSWs not providing enough time or assistance to residents who require feeding assistance.

Resident #008 was included as part of the resident sample to inspect on the home's nutrition and hydration process for residents.

Review of resident #008's written plan of care at the time of the inspection showed that the resident was to be provided moderately-thickened fluids, and that the resident required feeding assistance.

Mealtime observation by inspector #646 on one unit showed that the beverage cart had one large carton of moderately-thickened water, and one large carton of mildly-thickened juice. No other thickened juices were observed on the cart. Agency PSW #145 was observed to pour the moderately-thickened water into a cup and the mildly-thickened juice into another cup and provided both cups to resident #008. The inspector observed program staff #175 provide the mildly-thickened juice and moderately-thickened water to resident #008. The resident was observed to cough after several spoonfuls of juice, and the program staff stopped feeding the resident to allow the resident to clear their throat.

Interview with agency PSW #145 showed that they had access to the electronic records for residents, but the staff had not checked the records before serving

residents their meals, and no dietary binder was on the cart at the point of service.

In an interview, the FSM stated that resident #008 should have received moderately-thickened water and moderately-thickened juice, not mildly-thickened juice. Interview with the FSM stated that the process prior to the outbreak was for special beverages, such as thickened fluids, to be poured out by dietary staff and labeled for specific residents. This process was put on hold during the outbreak, and the PSWs were currently to pour the thickened beverages from the cart for the residents. The FSM clarified that there are no thickeners on the serving carts, but the home has both packaged moderately and mildly thickened water and juices that were to be poured for residents. The FSM stated it is the dietary staff who prepare the juice carts, and the cart should have both moderately-thickened water and moderately-thickened juice for the PSWs to pour. Observation of the dietary storage room showed that moderately thickened water and moderately-thickened juices, and mildly-thickened water and mildly-thickened juices were stocked and available. The FSM stated that the dietary staff preparing the cart may not have looked carefully at the boxes of thickened fluids and did not provide the correct fluids for PSWs to use on the cart. There was increased risk of swallowing difficulties for resident #008 when they were provided fluids that were not thickened to the level that the resident needed.

Interview with the acting DOC stated that the staff should collaborate to ensure residents receive the diet and fluids as per their plan of care, and this was not done for resident #008 who required moderately-thickened fluids, when the dietary staff placed mildly-thickened rather than moderately-thickened juice on the beverage cart, and the PSW poured mildly-thickened juice for the resident, and the activity staff provided the mildly-thickened juice for resident #008. (646)

4. Resident #004 was included as part of the resident sample to inspect on the home's nutrition and hydration process for residents.

Review of resident #004's electronic written care plan at the time of the inspection showed that the resident was to be provided moderately-thickened fluids with feeding assistance from the staff.

Mealtime observation by inspector #646 showed that the beverage cart had one large carton of moderately-thickened water, and one large carton of mildly-thickened juice. No other thickened juice was observed on the cart. Agency PSW #131 was observed to pour one cup of moderately-thickened water and one cup of mildly-thickened juice, and the PSW brought both cups to resident #004. PSW #131 was observed providing mildly-thickened juice to the resident by holding the cup while the resident took a sip from the cup. No coughing was observed. Agency PSW #131 continued to assist the resident with their meal.

In an interview with PSW #131, they stated that they are aware the resident is to have moderately-thickened fluids, but they did not read the label on the boxes of thickened water and juice from the beverage cart, and was not aware that the juice was mildly-thickened.

In an interview, the FSM stated that resident #004 should have received moderately-thickened water and moderately-thickened juice, not mildly-thickened juice. Interview with the FSM stated that the process prior to the outbreak was for special beverages, such as thickened fluids, to be poured out by dietary staff and labeled for specific residents. This process was put on hold during the outbreak, and the PSWs were currently to pour the thickened beverages from the cart for the residents. The FSM clarified that there are no thickeners on the serving carts, but the home has both packaged moderately and mildly thickened water and juices that were to be poured for residents. The FSM stated it is the dietary staff who prepare the juice carts, and the cart should have both moderately-thickened water and moderately-thickened juice for the PSWs to pour. Observation of the dietary storage room showed that moderately thickened water and moderately-thickened juices, and mildly-thickened water and mildly-thickened juices were stocked and available. The FSM stated that the dietary staff preparing the cart may not have looked carefully at the boxes of thickened fluids, and did not provide the correct fluids for PSWs to use on the cart. There was increased risk of swallowing difficulties for resident #004 when they were provided fluids that were not thickened to the level that the resident needed.

Interview with the acting DOC stated that the staff should collaborate to ensure residents receive the diet and fluids as per their plan of care, and this was not

done for resident #004 who required moderately-thickened fluids, when the dietary staff placed mildly-thickened rather than moderately-thickened juice on the beverage cart, and the PSW poured and provided mildly-thickened juice to resident #004.

The severity of this issue was determined to be a level 2 as there was minimal harm or minimal risk to residents #003, #004, #007, and #008. The scope of the issue was a level 3 as it related to four of six residents reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection of the LTCHA that included:
- Compliance Order (CO) issued under s.6(4)(a) on November 29, 2017 (2017_644507_001).
- CO issued under s.6(4) on February 18, 2020 (2020_816722_0002).
(646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee must be in compliance with O. Reg. 79/10, s. 17 (1).

Specifically, the licensee shall ensure that:
1) Resident #006 and all residents' call bells are in good, working order.

2) There is a system in place in the home for staff to report to maintenance when the resident-staff communication and response system is not functioning properly, and that call bells will be fixed in a timely manner.

3) Call bell pagers are turned on, and the PSWs and registered staff carry their call bell pagers at all times when working with residents, and respond to activated call bells in a timely manner.

4) All PSWs and registered staff working in the home are trained or re-trained on how to use the call bell system.

5) A record of the training provided for staff is kept, and includes the dates the training(s) were held, and names and positions of staff who attended the training.

6) Audits of call bell alarm history logs to ensure call bells are completed to monitor call bell response time by staff.

7) A record is kept of the call bell audits, including residents' names and room numbers, date and time of the audit, issues identified, date the issue was resolved, and name of person doing the audit.

Grounds / Motifs :

1. The home has failed to ensure that the resident-staff communication response system was easily seen, accessed, and used by residents, staff and visitors at all times.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. The following concerns regarding standards of practice and quality of care concerns were noted by the CAF ACC specifically that residents were observed crying for help with staff not responding for 30 minutes to over two hours.

Resident #006 was included as part of the resident sample to inspect on the home's call bell / communication response system.

Review of the home's alarm history report call bell logs showed that there were no records for the entire LTCH for 23 days between April to May 2020.

Review of resident #006's call bell logs showed the following:
- On a day in May, the call bell alarmed from resident's room for an identified period of time before the call was acknowledged, and the reset button was pressed,
- On another day in May, the call bell alarmed from resident's room for an identified period of time before the call was acknowledged and the reset button was pressed, and for another hour and a half later in the day before the call was acknowledged, and the reset button was pressed.

Interview with the Environmental Services Manager (ESM) stated that the home had contacted the call bell management company, but the company was unable to retrieve the missing call bell alarm history records for the identified period above. The ESM stated there were no reports from the staff that the call bell system had shut down during this time, and they were not aware of it malfunctioning. They further stated that no other call bell alarm history records were missing outside of the period above.

Interview with the acting DOC stated that the PSWs should be checking residents' call bells on every shift, and report to the maintenance department if the call bells were not working. Interview with ADOC #185 stated that the ADOCs and the ESM have access to the call bell logs, but they were not aware of any process in place for regular review of the call bell logs to check that the call bells were in proper working order.

The ESM stated that the call from the current call bell system goes directly to the pagers that PSWs were to carry on their person. The only way for staff to know which resident activated their call bell is through the call bell pager. However, at the end of April or beginning of May, the ESM had noticed the call bell pagers were turned off and left in the docking stations at the nursing station; the PSWs were not carrying the pagers with them. The ESM had reminded PSWs to carry

the pagers with them. The ESM stated they had also informed the acting DOC and ADOCs.

Observation by inspector #646 on the evening shift on one unit, identified three of five pagers were in the docking station, and the two PSWs assigned on the unit did not carry their call bell pagers.

Inspector #646's observation on another day during day shift on the same unit identified that three of the five pagers were in the docking station. Interviews with two PSWs and one RPN working on the unit showed that they did not carry call bell pagers.

Review of resident #006's current care plan showed: Place call bell within resident's reach, check that it is in working order and remind/encourage resident to use it.

Observation of resident #006 by inspector #646 during a day shift showed the resident had tried to activate their call bell three times, but the signal light by the head of the resident's bed did not light up, and there was no audible sound from the pagers in the hallway. The inspector also tested the call bell by activating it, but the signal light at the head of the resident's bed did not light up. The inspector notified RPN #118 that resident #006's call bell signal light did not turn on when the call bell was tested by the resident and the inspector. The RPN tested the call bell but the signal light at the head of the bed did not turn on, and there was no audible sound from the call bell pagers from the hallway. The RPN unplugged, then reconnected the call bell, pressed the call bell button, and the signalling light at the head of resident #006's bed began to blink. PSW #147 had also come in to resident #006's room to assist the RPN with the call bell, and showed the inspector that the resident's room number showed on their pager when the RPN activated the call bell.

Interview with resident #006 stated that they needed staff assistance for daily care. The resident stated that it is not usually a long wait for someone to answer the call bell, but occasionally, depending on how busy the staff are, it may take longer. The resident recalled an incident where they needed staff attention for personal care and had to wait for a long time, but they could not recall the date of the incident.

In an interview with PSW #147, they stated that resident #006 may have loosened the connection between the call bell and the wall when the resident was pulling on the call bell cord, so that when the resident attempted to activate the call bell, no signal was received. The PSW showed the inspector that resident #006's room and bed number showed up on the call bell pager when the nurse activated the call bell earlier.

Interview with the acting DOC stated that the PSWs and registered staff are expected to answer the call bells in a timely manner. The acting DOC explained that the length of time seen between activation and acknowledgement of call bells on the call bell alarm history reports may be that the staff had responded to the resident but did not cancel the call bell button.

The acting DOC further stated that the home's resident-staff communication response system, which was to be seen, accessed, and used by residents and staff at all times, were the call bell and the call bell pagers. They stated the PSWs and registered staff were expected to carry their call bell pagers so that they would be alerted if residents called for assistance, and that this was not done for resident #006. (646)

2. . Resident #014 was included as part of the resident sample to inspect on the home's call bell / communication response system.

Review of resident #014's current care plan showed: Place call bell within resident's reach, check that it is in working order and remind / encourage to use it.

Review of the home's alarm history report call bell logs showed that there were no records for the entire LTCH for 23 days between April to May 2020.

Review of resident #014's call bell logs showed the following:
- On a day in April 2020 the call bell alarmed from resident #014's room for an identified period of time before the call was acknowledged, and the reset button was pressed.
- On another day in April 2020, the call bell alarmed from the resident's room for an identified period of time before the call was acknowledged, and the reset

button was pressed;
- On a day in May 2020, the call bell alarmed from the resident's room for an identified period of time before the call was acknowledged, and the reset button was pressed;
- On a day in May 2020, the call bell alarmed from the resident's room for an identified period of time before the call was acknowledged, and the reset button was pressed.

Resident #014 was not cognitively able to be interviewed.

Inspector #646 tried resident #014's call bell on day shift, and the signal light turned on at the head of resident #014's bed. No staff member came in to the resident's room after the inspector waited for an identified period of time. The inspector observed that seven of ten call bell pagers were left in the docking station for that floor. The call bell pagers were turned off and no sound was heard. After another identified period of time, the inspector observed that resident #014's call bell signal continued to illuminate at the head of the resident's bed. Interviews with PSWs #132, #179, and #180 revealed that all three PSWs on the unit were not carrying call bell pagers.

In an interview with PSW #179, they stated that they didn't carry a call bell pager with them during their shift that day, but showed the inspector where the call bell pagers were. When the PSW turned on one call bell pager, all pagers began to alarm. The PSW showed the inspector that resident #014's room number was displayed on the pager, showing that their call bell had been activated. PSW #179 further stated that resident #014 usually calls out to the staff if they needed assistance.

In an interview, PSW #180, they stated that it was busy on the unit during their shift, and the staff did not carry their call bell pager. However, the PSW acknowledged that it was the practice for staff to carry call bell pagers to know which resident is asking for help, and whether the resident needed help in their room or in their washroom. The PSW stated the call bell could only be cancelled in the room where the call was activated and could not be cancelled from the pager.

Interview with the acting DOC stated that the PSWs and registered staff are

expected to answer the call bells in a timely manner. The acting DOC explained that the length of time seen between activation and acknowledgement of call bells on the call bell alarm history reports may be that the staff had responded to the resident but did not cancel the call bell button.

The acting DOC further stated that the home's resident-staff communication response system, which was to be seen, accessed, and used by residents and staff at all times, were the call bell and the call bell pagers. They stated that PSWs and registered staff were expected to carry their call bell pagers so that they would be alerted if residents called for assistance, and that this was not done for resident #014. (646)

3. Resident #020 was included as part of the resident sample to inspect on the home's call bell / communication response system.

Review of resident #020's current care plan indicated: Place call bell within resident's reach, check that it is in working order and remind / encourage to use it.

Review of the home's alarm history report call bell logs showed that there were no records for the entire LTCH for 23 days between April to May 2020.

Review of resident #020's call bell logs showed the following:
- On a day in May 2020, the call bell alarmed from resident #020's room for an identified period of time before the call was acknowledged, and the reset button was pressed.

Observation conducted by inspector #764 on day shift showed that seven of ten call bell pagers were observed in the docking station for that floor.

In an interview, resident #020 stated that they noticed many of the staff do not carry their call bell pagers. The resident stated they have noticed some of the residents have to cry out asking for the staff to assist them. The resident further stated that a PSW had told them they couldn't hear the residents' call bells because they were not carrying the pager. The resident could not remember which PSW it was. Resident #020 further stated that if they needed staff's assistance, instead of using the call bell, they would go directly to the nursing

station to call the staff.

Interview with the acting DOC stated that the home's resident-staff communication response system, which was to be seen, accessed, and used by residents and staff at all times, were the call bell and the call bell pagers. They further stated that PSWs and registered staff were expected to carry their call bell pagers so that they would be alerted if residents called for assistance, and that this was not done for resident #020.

The severity of this issue was determined to be a level 2 as there was minimal harm or minimal risk to residents #006, #014, and #020. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 2 compliance history as they had previous non-compliance to a different subsection of the LTCHA. (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 36.

The licensee must submit a plan to ensure that direct care staff are transferring residents with the recommended mechanical devices as specified in the residents' plans of care at all the times.

The plan shall include but not be limited to the following:
1) Completion of assessments of the proper slings required for each resident, and the record kept and available for PSWs and regular staff to check to determine which sling a resident requires.

2) Training/re-training for PSWs on safe transferring and positioning devices or techniques when assisting residents, including but not limited to how to assess and determine the proper sling required for each resident, and safe and proper use of slings for various kinds of lifts as required for the resident.

3) Maintain a written record of all education materials, including attendance sign in sheet.

4) Develop a plan to test and monitor staff knowledge and compliance on using safe transferring and positioning devices or techniques when assisting the residents.

Please submit the plan to inspector Ivy Lam at ivy.lam@ontario.ca by September 18, 2020.

Grounds / Motifs :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. The following concerns regarding identified altered skin integrity care were noted: Forceful and aggressive resident transfers.

Resident #019 was included as part of the sample to observe transferring of residents in the home. Review of the resident's quarterly assessment showed that resident #019 needed physical assistance and identified transfer equipment for mobility and transfer.

Review home's transfer assessment component guide showed that resident #019 should use an identified size of transfer equipment component. Review of the resident's written plan of care also directed staff to use the same size of transfer equipment component.

Observation of resident #019 by inspector #764, showed that two PSWs used a different transfer equipment component than what was stated in the resident's care plan. PSW #136 stated that all the residents have their own transfer equipment component. The PSW checked the name on the component and saw that the component had another resident's name on it, and the PSW mentioned that it was the only identified component of transfer equipment available in the room and checked it with the regular PSW.

The regular PSW #106 stated that they always used the same transfer equipment component for resident #019's transfers and stated that all transfer equipment components were the same and did not differ in size.

During interview with Staff Education Coordinator, they stated training on the identified transfer component was not a part of general orientation, but there was a section for use of identified transfer equipment in the online learning for all the newly hired PSW and registered staff.

During interview with PSW #136, they stated that they had not received any transfer education or transfer equipment component education at the point of

hire but later completed it through online learning.

During interview with RN #103, they stated that they expected the PSWs to check the electronic records and the resident's written plan of care to identify and use the designated transfer equipment component for each resident to promote safe transfers of residents. RN #103 stated that there was no Special Project Nurse (SPN) since the identified outbreak started in the home, who was supposed to follow up to ensure the transfer equipment components were labeled with the correct residents' names.

During interview with the acting DOC, they stated the last audit on transfer equipment and transfer equipment component was done several months ago, and there had been no follow up since. (764)

2. Resident #007 was included as part of the resident sample as a result of non-compliance found for resident #019 related to transfer and positioning.

Resident #007's quarterly assessment, indicated the resident needed physical assistance and used an identified transfer device to transfer between surfaces.

Review of the home's transfer assessment component guide showed that resident #007 should use an identified size of transfer equipment component. Review of the resident's written plan of care also directed staff to use the same size of transfer equipment component.

Observation of resident #007 by inspector #764, showed that PSW #143 and PSW #180, used a different transfer equipment component that was stated in the resident's plan of care.

During interview with Staff Education Coordinator, they stated training on the identified transfer component was not a part of general orientation, but there was a section for use of identified transfer equipment in the online learning for all the newly hired PSW and registered staff.

During interview with PSW #180 and PSW #143, they stated they had received education on transfer equipment component about a year ago, and they were supposed to check the names on the identified component of transfer equipment

to ensure they were using the right one for the residents.

During interview with RN #103, they stated that they expected the PSWs to check the electronic records and the resident's written plan of care to identify and use the designated transfer equipment component for each resident to promote safe transfers of residents. RN #103 stated that there was no SPN since the identified outbreak started in the home, who was supposed to follow up to ensure the transfer equipment components were labeled with the correct residents' names.

During interview with the acting DOC, they stated the last audit on transfer equipment and transfer equipment component was done several months ago, and there had been no follow up since. (764)

3. Resident #005 was included as part of the resident sample as a result of non-compliance found for resident #019 related to transfer and positioning.

Review of the home's transfer assessment component guide showed that resident #005 should use an identified size of transfer equipment component. Review of the resident's written plan of care stated the resident required assistance with transfer, and also directed staff to use the same size of transfer equipment component.

Observation by inspector #646 showed that PSWs #131 and #147 had used and identified transfer component that was different than what was stated in resident #005's written plan of care to transfer the resident.

During interview with PSW #147, they stated there was a binder which clarified which transfer equipment component sizes were to be used for each resident who required it. However, upon reviewing the binder with the inspector, the PSW stated that the documents with residents' transfer equipment component size was missing from the binder.

During interview with Staff Education Coordinator, they stated training on the identified transfer component was not a part of general orientation, but there was a section for use of identified transfer equipment in the online learning for all the newly hired PSW and registered staff.

During interview with RN #103, they stated that they expected the PSWs to check the electronic records and the resident's written plan of care to identify and use the designated transfer equipment component for each resident to promote safe transfers of residents. RN #103 stated that there was no SPN since the identified outbreak started in the home, who was supposed to follow up to ensure the transfer equipment components were labeled with the correct residents' names.

During interview with the acting DOC, they stated the last audit on transfer equipment and transfer equipment component was done several months ago, and there had been no follow up since. (764)

4. Resident #028 was included as part of the resident sample as a result of non-compliance found for resident #019 related to transfer and positioning.

Review of resident #028's most recent quarterly assessment showed that the resident required assistance and identified transfer equipment for transfer.

Review of the home's transfer assessment component guide showed that resident #028 should use an identified size of transfer equipment component. Review of the resident's written plan of care directed staff to use an identified transfer equipment with two staff, and also directed staff to use the same size of transfer equipment component.

Inspector #764's observation of PSW #127 showed that they did not use the identified transfer equipment to transfer the resident. The PSW explained to the inspector that the resident was able to transfer from bed to chair by themselves and needed only one-person assistance to transfer, but they required the use of a transfer equipment for transfer from chair to bed. PSW #127 showed the inspector that resident had two transfer equipment components. However, both of these transfer components were different from the size than what was stated in resident #028's written plan of care.

During interview with Staff Education Coordinator, they stated training on the identified transfer component was not a part of general orientation, but there was a section for use of identified transfer equipment in the online learning for all the

newly hired PSW and registered staff.

During interview with PSW #127, they stated that they had worked with the same residents for about a year and knows the residents, but if they were working with a new resident, they would check the resident's plan of care.

During interview with RN #103, they stated that they expected the PSWs to check the electronic records and the resident's written plan of care to identify and use the designated transfer equipment component for each resident to promote safe transfers of residents. RN #103 stated that there was no SPN since the identified outbreak started in the home, who was supposed to follow up to ensure the transfer equipment components were labeled with the correct residents' names.

During interview with the acting DOC, they stated the last audit on transfer equipment and transfer equipment component was done a several months ago, and there had been no follow up since. (764)

5. Resident #031 was included as part of the resident sample as a result of non-compliance found for resident #019 related to transfer and positioning.

Review of resident #031's quarterly assessment, showed that the resident was totally dependent for mobility and transfer, and required physical assistance and use of an identified transfer equipment.

Review of the home's transfer assessment component guide showed that resident #005 should use an identified size of transfer equipment component. Review of the resident's written plan of care stated the resident required two staff assistance with transfer, using an identified transfer equipment, and also directed staff to use the same size of transfer equipment component as the guide assessed.

Observation of resident #031 by inspector #764, showed that the staff had completed the transfer for the resident from bed to wheelchair. The inspector observed that two PSWs were in the room, and PSW #127 was holding a transfer equipment component that was different than what was stated in resident #031's written plan of care.

During interview with Staff Education Coordinator, they stated training on the identified transfer component was not a part of general orientation, but there was a section for use of identified transfer equipment in the online learning for all the newly hired PSW and registered staff.

During interview with PSW #139, they stated they did not receive any education from the home on the use of transfer equipment and transfer equipment component but learned it from other PSWs working in the unit. They stated to ensure that they were using the right identified component of transfer equipment for the resident, they would check if the resident's name was on it.

During interview with PSW #127, they stated had worked in the same assignment for over a year, with the same residents and know them; but if working with a new resident, they will check the care plan.

During interview with RN #103, they stated that they expected the PSWs to check the electronic records and the resident's written plan of care to identify and use the designated transfer equipment component for each resident to promote safe transfers of residents. RN #103 stated that there was no SPN since the identified outbreak started in the home, who was supposed to follow up to ensure the transfer equipment components were labeled with the correct residents' names.

During interview with the acting DOC, they stated the last audit on transfer equipment and transfer equipment component was done several months ago, and there had been no follow up since.

The severity of this issue was determined to be a level 2 as there was minimal harm or minimal risk to the residents. The scope of the issue was determined to be a level 2 as it affected five of the seven residents reviewed. The home had a level 3 compliance history as the home has previous non-compliance to the same subsection.
The home's compliance history included the following non-compliance with the same subsection that included:
- CO issued under r. 36 on November 29, 2017 (2017_644507_0016). (764)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Oct 19, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 50 (2).

Specifically, the licensee shall ensure that:

1) Skin and wound re-training is provided to registered staff working in the home for, but not limited to, the following:
a) The process for referral to a registered dietitian (RD) who is a member of the staff of the home, for assessment of a resident exhibiting altered skin integrity for the adequacy of nutrition and hydration, to promote wound healing.
b) A record is maintained for the training above, including the names and signatures of all registered staff who have been re-trained, the date the training was provided, the method of training provided, and the materials presented.

2) All PSWs and registered staff working in the home receive updated training on the following:
a) The definition of altered skin integrity, and what type of conditions should be reported and treated as altered skin integrity based on the home skin and wound care program.
b) A post-training evaluation is conducted to ensure comprehension of the education, and that the evaluation records are kept.
c) An auditing system is implemented to ensure that for any resident exhibiting altered skin integrity, the PSWs report and document the altered skin integrity and registered staff of the home provide immediate treatment and interventions to reduce or relieve pain, promote healing and prevention. The auditing system should be conducted randomly for a period of three months following the service of this order.

3) Ensure that residents #011, #033, and any other resident with altered skin integrity who require assistance are provided turning and repositioning assistance as scheduled in the residents' plan of care.

4) An auditing system is developed in the home to ensure staff are assisting residents with turning and repositioning using safe techniques in accordance to each resident's plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #001, #002, #003, and #018

with identified altered skin integrity, received immediate treatment and interventions to promote healing, and prevent infection, as required.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. The following concern regarding identified altered skin integrity care were noted: Increased number and complexity of identified altered skin integrity.

Review of resident #001's care plan, indicated that the resident was to receive treatment to an area of altered skin integrity, monitoring, weekly assessment, positioning, and nutritional supplement. It showed the resident required extensive assistance and physical assist for bed mobility.

Review of an altered skin integrity risk assessment showed that resident #001 was at high risk for developing altered skin integrity.

Review of resident #001's progress notes showed that the resident had a new area of altered skin integrity on an identified date. Over the next 30 days, there was identified deterioration of resident #031's altered area of skin integrity. At the end of the 30 days, when the resident was found with new and additional symptoms, they were transferred to the hospital.

Review of the resident's quarterly assessment showed that the resident had a worsening altered skin integrity at 27 days after it was first identified.

During interview with RPN #108, they stated that, resident #001's area had worsened since their first follow up assessment, nine days after it was first identified.

Review of the resident's identified altered skin integrity assessment history indicated that the resident's area was assessed nine days after it was first identified, then continued to worsen in the next three assessments.

Review of the resident's area dressing orders showed that although the area had worsened over the month, no changes were made to the treatment orders.

During interview with RPN #108, they stated that during the identified disease

outbreak, they were assigned to work on different units as RPN and in addition to being in charge of completing residents' altered skin integrity assessments. They stated that prior to the outbreak, resident #001 did not have the altered area of skin integrity.

During interview with EES, they stated that skin and area training was included in the general orientation for staff under the online learning.

During separate interviews with acting ADOC #129 and RPN #108, they stated the PSWs had received specific education regarding skin care and application of therapeutic barrier cream.

Observation by inspector #764 showed that the skin and altered skin integrity care binder, including the altered skin integrity care protocols, skin and altered skin integrity orientation checklist, skin and altered skin integrity framework, instruction regarding digital assessment and reporting of new skin integrity impairment form were available on all units.

During an interview, PSW #115 stated that they would report any changes in residents' skin integrity condition to the nurses and that the PSWs would correctly apply the barrier treatment cream for residents to prevent the skin breakdown.

Observation by inspector #764 showed that PSW #127 had reported their assigned residents' skin conditions to RPN #126.

During separate interviews with RPNs #112, #118, #126 and #117, they stated upon PSWs' report of any new or worsened skin integrity condition, they would follow the skin and area protocols, start the assessment process by taking the digital pictures, enter the assessment information and send referrals to the skin and area lead, RD and inform the Substitute Decision Maker (SDM). They stated the skin and wound care lead would consult with physician, manage the treatment orders and coordinate the weekly skin and area assessment.

During interview with the skin and area lead (RPN #108), they stated that an identified altered skin integrity assessment should be done upon discovery of a new identified altered skin integrity or a change in the identified altered skin

integrity condition. This was not done for resident #001 based on assessment data, when the identified altered skin integrity had subsequently deteriorated. (764)

2. Resident #002 was included as part of the resident sample as a result of non-compliance found for resident #001 related to skin and identified altered skin integrity care.

Review of resident #002's progress notes showed that on identified date, an altered area of skin integrity was identified for the resident.
- A wound assessment for the resident the next day identified the resident had an area of altered skin integrity.
- A note seven days later showed an RD referral was completed.
- Ten days later, the resident was sent to the hospital related to an identified infection.

During interview with the skin and area lead (RPN #108), they indicated that the first time the resident's identified altered skin integrity was recorded that it was already progressing and there were no treatment or interventions in place to prevent deterioration. Interviews with the skin and area lead, two other RPNs and one RN, further stated that if the PSWs reported any skin and area issues to the nurse, the resident would be assessed, picture would be taken, referrals sent to the RD and the skin and area lead, and treatment would be started per identified altered skin integrity protocol. (764)

3. Resident #003 was included as part of the resident sample related to non-compliance found for resident #001 related to skin and identified altered skin integrity care.

Review of resident #003's progress notes showed that the resident had an altered skin integrity.
- Documentation on the next day showed it had worsened.
- The initial assessment was done 13 days after the area was first identified.
- Review of the resident's identified skin and area assessments showed that the next three weekly area assessments were completed on time.

The resident's quarterly assessment, completed 21 days after it was identified,

showed that the altered skin integrity had deteriorated.

During interview with RPN #108, they stated although the first report of the identified altered skin integrity was recorded, no assessment was done for resident #003 and the first identified altered skin integrity assessment was done on two weeks later. They stated if the nurses did not take a picture and send the referral, they will not be aware of the identified altered skin integrity. They further stated that if the PSWs reported any skin and identified altered skin integrity issue to the nurse, the identified altered skin integrity was assessed, picture was taken, referrals were sent to the RD and identified altered skin integrity care lead and treatment would be started per identified altered skin integrity protocol. (764)

4. Resident #018 was included as part of the resident sample as a result of non-compliance found for resident #001.

Review of the resident #018's progress notes recorded the first report of an identified altered skin integrity.

During interview with RPN #108, they stated that resident #018 was independent with bed mobility. RPN #108 stated that the deterioration of the resident's altered skin integrity was not captured before it had progressed and agreed that an identified altered skin integrity assessment was needed for any new identified altered skin integrity and any change in identified altered skin integrity condition. They added that the PSWs had provided the continence care and changed the resident daily and didn't report the altered skin integrity although they had received training and education. RPN #108 further stated that if the PSWs had reported any skin and identified altered skin integrity issue to the nurse, the area would be assessed, pictures would be taken, and referrals would be sent to the RD and the skin and wound care lead and the treatment would be started per identified altered skin integrity protocol. (764)

5. The licensee has failed to ensure that residents #001, #002, and #003, who exhibited altered skin integrity, were assessed by the registered dietitian.

Review of skin risk assessment and head-to-toe skin assessment in resident care and services manual (RCS G-35-05, last revised date: July 29, 2019)

indicated: The skin care coordinator and registered dietitian should be notified when a resident is exhibiting altered skin integrity (this includes skin tears, bruises, identified altered skin integrity and any other identified altered skin integrity or skin breakdown), the Substitute Decision Maker (SDM) and physician.

Review of the home's identified altered skin integrity care protocol indicated RD referral should be sent for at an identified skin integrity at identified stage or any deep tissue injury.

Review of the home's skin and identified altered skin integrity framework indicated: RD referral is required for skin tear, pressure injury, blister, cancer lesion, laceration, open lesion, surgical identified altered skin integrity and venous identified altered skin integrity.

Review of the home's quick reference guide for skin and identified altered skin integrity, indicated that an RD referral should be sent for skin tears and all other skin related injuries.

Review of skin and identified altered skin integrity orientation checklist for registered staff, indicated to send an electronic RD referral as a part of documentation for newly discovered identified altered skin integrity and/or skin impairment: pressure injuries, venous ulcers, arterial ulcers, diabetic ulcers, palliative ulcers, skin tears, rashes, and bruises etc.

Based on Braden Scale for Predicting Pressure Sore Risk, showed that resident #001 was at high risk for developing identified altered skin integrity.

Review of resident #001's progress notes showed that the resident had a new area on an identified date. Over the next 30 days, there was identified deterioration of resident #031's altered area of skin integrity. At the end of the 30 days, when the resident was found with new and additional symptoms, they were transferred to the hospital.

Review of the resident's quarterly assessment indicated that the resident had an altered skin integrity.

Review of the PCC dashboard showed that RD #207 noted a decline in referrals for residents in the home.

During interview with RD #198, they stated that nurses should send the RD referrals for any type of skin integrity impairment except bruise, rash, pimples and abrasion and they noticed during identified disease outbreak, they were not receiving referrals.

During interviews with RPN #108, RPNs #118 and #128, and RN #103, they stated that there was a skin and identified altered skin integrity binder where all the units have access to identified altered skin integrity care protocols and guidelines, and they were aware that RD referrals should be sent upon any new or change in skin condition.

During interview with the RPN #108, they stated based on progress notes, the identified altered skin integrity was recorded and the condition has changed. RPN #108 stated an RD referral needed to be sent whenever there was a new identified altered skin integrity or a change in the identified altered skin integrity condition. For resident #001 an RD referral was not sent when the resident's skin condition changed. (764)

6. Resident #002 was included as part of the resident sample as a result of non-compliance found for resident #001.

Review of resident #002's progress notes showed that a skin breakdown was recorded for the resident on an identified date. On the next day, the altered skin integrity was assessed to be at a deteriorated condition. At the end of a 30-day period, the altered skin integrity continued to be at the same deteriorated condition.

Interviews with RPN #118, RN #103 and RPN #128 confirmed that an RD referral should be sent upon any change in the resident's skin condition.

During interview with RD #198, they stated nurses should send the RD referrals for any type of skin integrity impairment except bruise, rash, pimples and abrasion, and they noticed that they were not receiving these referrals during the outbreak.

During interview with RPN #108, they stated a referral should be sent to the RD whenever there was a new identified altered skin integrity or a change in the identified altered skin integrity condition, and for resident #002, an RD referral was not sent until the area had further deteriorated. (764)

7. Resident #003 was included as part of the resident sample as a result of non-compliance found for resident #001.

Review of the resident #003's progress notes showed that the resident had an altered area of skin integrity on an identified date.
- Documentation on the next day showed that the area had worsened.
- The initial area assessment was done 13 days after it was first identified.
- The RD referral sent 15 days after it was first identified, and the RD assessment was completed on the same day.

During interview with RD #198, they stated nurses should send the RD referrals for any type of skin integrity impairment except bruise, rash, pimples and abrasion and they noticed during the outbreak, they were not receiving these referrals.

Interview with RPN #108 stated, a referral should be sent to the RD whenever there was a new identified altered skin integrity or a change in the identified altered skin integrity condition, and for resident #003, no RD referral was sent when the new identified altered skin integrity was noted. (764)

8. The licensee has failed to ensure that residents #011 and #033, who were dependent on staff for repositioning, were turned and repositioned every two hours.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. The following concern regarding identified altered skin integrity care was noted: No turning or repositioning of residents.

Resident #033 was included as part of the resident sample to inspect on the home's palliative care program.

Review of resident #033's quarterly assessment showed they required assistance to move to and from a lying position, turn from side to side, and for staff to position the resident's body while they were in bed.

Review of progress note between over a six-month period showed three documentations of turning and repositioning for the resident.

Review of the resident's written plan of care stated staff were to turn and reposition the resident every two hours and as needed, monitor for moaning, facial grimacing, guarding, rigidity and obvious discomfort, and to notify the registered staff immediately if concerns are noted.

On three different dates and various times throughout the day, observations made by inspector #764 identified the resident was not repositioned.
During interview with RN #103, they stated resident #033 required repositioning every two hours as indicated as a task in the electronic documentation for PSWs.

During interview with EES #153, they stated turning and reposition is a part of skin and identified altered skin integrity care online learning in staff general orientation.

During interview with PSW #102, they stated they did it in the morning once for resident #033 and not again. They mentioned that resident #033 wanted to be on their back in the bed whenever PSW #102 offered to change the position.

During interview with PSW #139 on identified date, two hours after starting the shift, they stated they usually turned resident #033 three times per shift, but they hadn't repositioned the resident at all as they were busy serving the snacks.

During interview with RN #103, they stated that for resident #033 turning and repositioning every two hours. The directions in the care plan should be followed by PSW staff. Observations by inspector #764 on identified dates, showed that the resident was not turned and repositioned.

During interview with RPN #108, they stated they expected PSWs to follow the

directions in the POC task and turn and reposition resident #033 every two hours. They stated that based on inspector #764's observations mentioned above, turning and repositioning for resident #033 was not done. (764)

9. Resident #011 was included as part of the resident sample related to non-compliance found for resident #033 related to turning and repositioning of residents.

Review of resident #011's RAI-MDS assessment, showed that resident #011 was totally dependent and required two persons physical assist for bed mobility.

Review of progress notes indicated resident #011 to be turned to prevent further skin break down.

Review of plan of care indicated turn, reposition at least every two hours, more often as needed or requested and observe resident pressure points.

On two different dates and various times throughout the day, observations made by inspector #764 identified the resident was not repositioned.

During an interview with PSW #144, they stated that resident #011 had to be repositioned every two hours but they didn't want to interfere with care the resident was to receive, so repositioning was not done for resident #011 as per the care plan.

During interview with PSW #145, they stated that they did not receive any instruction regarding turning and positioning of the resident, but they did provide assistance to the resident twice during their shift; although they were not the primary PSW assigned to the resident.

During interview with RPN #108, they stated they expected the PSWs to follow the POC, and to turn and reposition resident #011 every two hours, and that if the resident was turned and repositioned, they would not be observed to be in the same position for entire shift by the inspector. They further stated that, based on the inspector #764 observations above, turning and repositioning for resident #011 was not done.

The severity of this issue was determined as level 3 as there was an actual harm or actual risk to the residents. The scope of the issue determined to be level 3 as it affected four out of four residents reviewed. The home had a level 3 compliance history as the home has previous non-compliance to the same subsection in the last 36 months. The home's compliance history included the following non-compliance with the same subsection that included:

- CO issued on September 11, 2017 (2017_527665_0004) for r.50(2).
- Written Notice (WN) and Voluntary Plan of Correction (VPC) issued on November 1, 2019 (2019_ 767643_0027) for r.50(2)(b)(ii).
- WN, VPC, and CO issued on November 1, 2019 (2019_ 767643_0027) for r.50(2)(b)(i).
- WN issued on February 18, 2020 (2020_816722_0002) for r.50(2)(b)(i).
- WN issued on February 18, 2020 (2020_816722_0002) for r.50(2)(b)(iii).
- WN issued on February 18, 2020 (2020_816722_0002) for r.50(2)(b)(iv). (764)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be in compliance with O. Reg. 79/10, s. 229 (4).

Specifically, the licensee shall ensure that:
1) All staff receive re-education on proper use of PPE in the home, and while working with residents.

2) The Food Service Manager, Food Service Supervisor, Registered Dietitian(s), Director of Care, Assistant Directors of Care, and appropriate registered staff members, Personal Support Workers (PSWs) and Dietary Aides meet to discuss and identify how to provide meals and snacks to residents in a way that promotes infection prevention and control and minimizes risk of infection; and to communicate this with registered staff, PSWs, and dietary aides.

3) Staff serving residents' meals follow the strategies as identified in item #2.

4) A record is kept of the PPE training, including: Training content, date(s) of training, and names and positions of staff who attended.

5) Audits are performed to ensure staff are using PPE as appropriate.

6) Audits are performed to ensure that meals and snacks are provided to residents as identified from item #2.

7) A record is kept of the audits from items #5 and #6, including dates of the audits, issues identified, and follow-up actions taken to resolve the identified issues.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff participated in the implementation of the infection prevention and control program.

This inspection was initiated related to the 4th Canadian Division JTFC's Observation Report regarding concerns from the CAF ACC teams. The following concerns regarding infection prevention and control were noted: lack of training and adherence to Infection Prevention and Control (IPAC) protocols, and staff not changing Personal Protective Equipment (PPE) for several hours while moving between numerous resident rooms.

No concerns were identified related to the frequency of donning and doffing practices of registered staff and PSWs in the home during the period of onsite inspection.

The following IPAC concerns were observed by inspectors during the inspection:

I. PPE USE
A) On a day in May 2020, on one unit, a regular PSW was observed to don their reusable gown by tying a knot at the neck prior to wearing the gown and pulled the hole of the knotted gown over their head, while their mask and face shield remained on during this process. The PSW was observed to remove their gown by loosening the knot at the neck and pulling the gown off over their head. In an interview with the PSW, they stated that this was a practice they learned in school.

B) On another day in May 2020, on another unit, an agency PSW was observed to be wearing a face shield and two masks while providing care for residents on the unit. When donning a new gown, the PSW was observed to tie the neck strap of the gown prior to putting the gown on, making a hole for the head, and the PSW slid the pre-tied gown over their head and face shield. The neck area of the gown had contacted and wiped the front of the face shield, which had been worn in various residents' rooms, as the PSW donned their gown. The PSW's face shield was not observed to be cleaned or disinfected between residents.

In an interview with the PSW, they stated that they had received orientation and

training when they were hired. The PSW said that their method of donning gowns by tying a knot prior to wearing the gown was a method they had learned in school. They further stated that they would use this method of donning while keeping their mask and face shield on. The PSW further stated that it was their own practice to wear two masks, and they would take the outer mask off and keep the inner mask on if they need to change it.
Review of the staff orientation sign-in sheet showed the agency PSW had received Orientation, which included multiple IPAC components, including proper donning and doffing of PPE.

C) On another day in May 2020, on another unit, a regular PSW was observed by inspector #646 to walk from the nursing station and entered a resident's room while holding a container in their hands without a mask on their face. The PSW exited the room holding the container several minutes later. The PSW told the inspector that they are not wearing their mask because they had just finished their own meal and was washing their meal container. The staff had washed their meal container in the resident's room.

Interview with the PSW stated that they had received SURGE (online) training and in service in the home related to infection prevention and control practices every year. Review of the PSW online learning records showed their last IPAC training in 2020, and had also completed additional training on PPE donning and doffing.

D) On another day in May 2020, on another unit, an agency PSW was observed to wear two masks while preparing the servery cart with meals for residents. The PSW stated they would take the outer mask off and keep the inner mask on if they need to change their mask.

Review of the staff orientation sign in sheets did not show records for agency PSW #170 when they were first hired, but review of the SURGE training records showed that PSW #170 received their SURGE orientation and onboarding training about two months after they were hired.

Interview with the Employee Engagement Specialist (EES) indicated that they had provided Rapid Onboarding training to the staff members for two agencies, but had not facilitated the training for the staff hired through the other agencies

outside of those two.

In an interview, the Staff Education Coordinator stated that prior to the outbreak, the staff in the home received IPAC training in the fall of 2019, which included hand hygiene, cleaning and disinfection, and policy of cleaning and disinfecting equipment. Additional training was added at the start of 2020 on how to use PPE, and on donning and doffing. The Staff Education Coordinator was away from the home for about one month between April and May 2020, and the EES had helped with training and orientation of staff while they were away. However, the online SURGE training had not been provided for new staff during the period when they were away.

In an interview, the home's Toronto Public Health / Communicable Diseases Investigator (CDI) stated that the recommended practice for donning is to do hand hygiene before putting the gown on, then put on the gown, the face mask, then eye protection as needed. Further, it would not be optimal to slide the gown over the used face shield or face mask, as the staff may be at risk of contamination. The CDI further stated that Toronto Public Health had not recommended for staff to wear double masks, as this was improper use of PPE and may increase risk of transmission of the disease, especially if staff were to remove one mask and not the other.

II. MEAL SERVICE

Observation of breakfast by inspector #646 showed that a PSW poured a hot beverage from the shared carafe into one resident's personal cup that the resident brought out of their room. The same carafe was observed to be used to pour a hot beverage into the disposable cups for other residents on the unit.

The PSW was also observed to pour juice from the open pitcher into another resident's personal container that the resident had brought out of their room. The same pitcher of juice was observed to be used to pour juice into disposable cups for other residents on the unit.

Separate interviews with the acting DOC and the ED, stated that there is a process for cleaning residents' personal items for use during meals by the

dietary staff; however, during the outbreak, staff should not be providing food and beverages using residents' personal items. The acting DOC further stated that if residents' personal containers are to be used for meal service, there should to be a process for cleaning the items. Further, specific directions would need to be put in those residents' care plans. The acting DOC stated this practice was not in place during the outbreak. The acting DOC further stated that the PSW should not have provided the hot beverage and juice into the two residents' personal beverage containers.

In an interview, the acting DOC stated that the staff were expected to follow the home's IPAC program and directions, and in the incidents mentioned above, the staff members did not do so.

The severity of this issue was determined to be a level 2 as there was minimal harm or minimal risk. The scope of the issue was a level 3 as it related to three of three floors reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection of the LTCHA that included:
- WN issued under r. 229. (4) on December 13, 2018 (2018_642698_0006). (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 26th day of August, 2020

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Ivy Lam

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