Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 2, 2020	2020_748653_0016	001285-20, 001645-20, 002715-20, 003474-20, 007689-20, 010577-20, 011699-20, 015783-20, 017198-20	Complaint

Licensee/Titulaire de permis

Southlake Residential Care Village
690 Grace Street NEWMARKET ON L3Y 8V7

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

Southlake Residential Care Village
640 Grace Street NEWMARKET ON L3Y 8V7

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

ROMELA VILLASPIR (653), JACK SHI (760)

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): August 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, September 2, 3, 4, 2020.

During the course of the inspection, the following intakes were inspected: Complaint Log #(s):

-001285-20 related to insufficient staffing, staff qualifications, resident's bill of rights, continence care, laundry, and the lack of recreation and social activities;
-001645-20 and 017198-20 related to insufficient staffing, basic foot care and nail care, continence care, housekeeping, and the lack of recreation and social activities;
-002715-20 related to insufficient staffing, hydration, and change in condition;
-003474-20 and 010577-20 related to allegation of staff to resident abuse and neglect, unsafe transfer and positioning, resident's bill of rights, medication administration, plan of care, and infection prevention and control;
-007689-20 related to allegation of staff to resident abuse, resident's bill of rights, medication administration, unsafe transfer, complaint procedures, infection prevention and control, hydration, continence care, plan of care, and wound care treatment;
-011699-20 related to insufficient staffing, continence care, resident's bill of rights, and unsafe transfer;
-015783-20 related to pain management, resident's bill of rights, continence care, wound infection, weight loss, dehydration, laundry, and infection, prevention and control.

During the course of the inspection, the inspectors toured the home, observed the residents, provision of care, staff to resident interaction, infection prevention and control practices, reviewed video clips, staffing schedule, clinical health records, complaint records, the home's investigation notes, employee records, staff training records, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, family members, Substitute Decision-Makers (SDMs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), RPN student, Registered Nurses (RNs), Life Enrichment Aides (LEAs), Life Enrichment Manager (LEM), Physiotherapist (PT), Registered Dietitian (RD), Food Service Supervisor (FSS), Food Service Manager (FSM), Environmental Manager (EM), Scheduling Clerks (SCs), Human Resources (HR), Medical Pharmacies Clinical Consultant, Attending Physicians (APs), Medical Director, Extendicare Long-Term Care Consultant, York Regional Police Detective Constable, Assistant Director of Care (ADOC), Director of Care (DOC), and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **18 WN(s)**
- **7 VPC(s)**
- **7 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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #008 was protected from abuse and free from neglect by the staff in the home.

Based on separate interviews with resident #008 and the Director of Care (DOC), and a review of selected video clips, it was noted that the resident was abused and neglected by three Personal Support Workers (PSWs).

Sources: Video clips from the resident's family, and interviews with resident #008 and the DOC. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a back-up plan for nursing and personal care staffing that specifically addressed situations where the home did not have enough staff to come to work.

The Ministry of Long-Term Care (MLTC) received four complaints from the Substitute Decision-Makers (SDMs), and family council regarding the home not having sufficient staffing levels to meet the care needs of the residents. The home's written staffing shortage plan reviewed in 2020, did not specifically address what would constitute as a staffing shortage, and how the home would meet the care needs of the residents in the event that the home had insufficient staff working on-site.

On a day in August 2020, there were 11 PSW shifts vacant. The home was not able to find replacement PSWs to come in to work, so the managers were called in to assist. Registered Nurse (RN) #106, who worked that shift, stated that some of the managers and additional staff members who came in that day were not trained in providing care to residents, and thus they were only helping out with certain tasks like feeding and portering. The DOC confirmed that the home's staffing back-up plan indicated that in the event they did not have enough staff to provide care to residents, the home would have all hands-on deck. However, it was not specific in describing how the care needs of residents would be met, as experienced by the home on a day in August 2020.

In addition, the Human Resources (HR) stated the home was currently close to a critical level in the shortage of staff, and the home has contacted three agency companies to provide more PSWs to work in the home. The DOC indicated the agency companies currently used by the home were not effective at providing additional PSWs to work at the home. The DOC also mentioned they were unsure that the home's current contingency plan was effective, and it would be difficult for the home to manage a second wave of COVID-19.

Sources: Review of records of staff who worked on a day in August 2020; the home's written staffing shortage plan last reviewed in 2020; Interviews with the DOC, HR, ESM, RN, Scheduling Clerks (SCs) and other staff, residents, and SDMs. [s. 31. (3)]

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 PSW #149 used safe transferring devices or techniques when they assisted resident #009.

A review of progress notes indicated on one occasion, PSW #149 transferred the resident without using the required lift machine and staff assistance. Separate interviews with Registered Practical Nurse (RPN) #115 and the DOC, indicated that resident #009 sustained an injury as a result of the unsafe transfer.

Sources: Resident #009's care plan; Point Click Care (PCC) progress notes; Interviews with RPN #115 and the DOC. [s. 36.]

2. The licensee has failed to ensure that PSW #152 used safe transferring techniques when they assisted resident #007.

Based on the review of the video clips and an interview with the DOC, on two different shifts, PSW #152 transferred resident #007 using the lift machine without the appropriate staff assistance. The DOC confirmed that PSW #152 did not use safe transferring techniques when they assisted resident #007, as observed in the video clips.

Sources: Video clips from the resident's family, and an interview with the DOC. [s. 36.]

3. The licensee has failed to ensure that PSWs #153 and #154 used safe transferring and positioning techniques when they assisted resident #008.

Based on the review of the selected video clips and an interview with the DOC, PSW #153 transferred resident #008 using the lift machine without the appropriate staff assistance, causing discomfort to the resident. In addition, PSW #154 was observed using unsafe positioning techniques when they assisted resident #008 in bed, causing discomfort to the resident. The DOC confirmed that PSWs #153 and #154 did not use safe transferring and positioning techniques when they assisted resident #008, as observed in the video clips.

Sources: Video clips from the resident's family, and an interview with the DOC. [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. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the hydration program included the implementation of interventions to mitigate and manage the identified risks related to hydration.

A review of the home's policy, titled "Food and Fluid Intake Monitoring", revealed that if a resident did not meet their individualized fluid target for three consecutive days, the nurse must complete a Nursing Hydration Assessment. The home's Registered Dietitian (RD) also indicated that a fluid serving was considered a cup or 125 milliliters (mls).

Resident #005's SDM forwarded a complaint related to the home's interventions when

the resident had a change in condition. The resident's care plan indicated they had a fluid target goal, and required monitoring of their hydration status. The resident's progress notes indicated on a day in July 2020, the resident had a change in condition, and was not taking in their fluids despite staff encouragement. A review of the resident's fluid intake, indicated they did not meet their fluid target goal on the day they had a change in condition, and two days prior. RPN #114 stated they were unaware of what a hydration assessment was and where to find a resident's daily fluid servings, thus, this was not done for the resident when they had a change in condition. The resident was subsequently sent to the Emergency at the hospital for treatment.

Sources: Interviews with RPN #114, resident #005's SDM and other staff; resident #005's progress notes, daily fluid intake and plan of care; Food and Fluid Intake Monitoring Policy. [s. 68. (2) (c)]

2. Resident #002's SDM brought forward a complaint related to how the home managed the resident's hydration needs. RPN #101 indicated the resident was at nutritional risk and had a fluid target goal. For a period of one month, the resident was not meeting their fluid target goal. A review of the electronic assessments did not show that a hydration assessment was completed during this period. PSW #100 mentioned that the night shift PSW used to calculate the residents' total daily fluid intake, and would inform the day shift to push fluids for residents that did not have a total of 1500 mls daily, however, this practice was stopped a while ago due to short staffing. RPN #101 stated they did not have a process in place to monitor this resident's fluid intake and would only do a hydration assessment, if a PSW stated to them that the resident was not drinking.

Sources: Interviews with RPN #101, PSW #100, resident #002's SDM and other staff; resident #002's plan of care, daily fluid intake and electronically documented assessments; Food and Fluid Intake Monitoring Policy. [s. 68. (2) (c)]

3. A review of resident #007's PCC physician order and an interview with the RD, indicated they were at nutritional risk and had a fluid target goal.

A review of the Point of Care (POC) fluid look back report for the months of May, June, and July, 2020, revealed that the resident only met their fluid target goal three times in June, and twice in July.

A review of PCC assessments indicated the last Clinical – Hydration Assessment completed by the registered staff for reduced fluid intake was in March 2019.

Separate interviews with RPNs #117, #123, and #129, indicated that previously, the night registered staff calculated the residents' daily fluid intake, and those who did not meet their fluid goals would be flagged to the day registered staff, and a hydration assessment would be completed. RPNs #117 and #123 confirmed that this practice had not been done this year.

Separate interviews with the Food Service Supervisor (FSS), Food Service Manager (FSM), RD, and the DOC, confirmed that resident #007's fluid intake was not being calculated by the registered staff, and that a hydration assessment was not completed, when they did not meet their individualized fluid target for three consecutive days, numerous times, in May, June, and July 2020.

Sources: PCC physician order; POC fluid look back report; PCC assessments; Interviews with RPNs #117, #123, #129, FSS, FSM, RD, and the DOC. [s. 68. (2) (c)]

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 PSW #152 and RPN #101 participated in the implementation of the Infection Prevention and Control (IPAC) program.

Based on the review of the video clips with the DOC, PSW #152 did not participate in the implementation of the IPAC program when providing care to resident #007. Furthermore, it was also observed that RPN #101 brought the wound treatment cart inside the resident's room, instead of leaving it outside, by the door. The DOC confirmed that PSW #152 and RPN #101 did not participate in the implementation of the IPAC program, as

observed in the video clips.

Sources: Video clips from resident #007's family, and an interview with the DOC. [s. 229. (4)]

2. The licensee has failed to ensure that RPN #101 participated in the implementation of the IPAC program, as it related to wearing a mask while interacting with resident #002 and their SDM.

Resident #002's SDM brought forward a complaint related to a visit at the home in August 2020, wherein they noticed RPN #101 entered the resident's room without a mask on, as they were eating. Under the LTCHA, Directive #3 was issued on April 15, 2020, which required all LTC staff to wear a surgical mask at all times. The RPN stated they were on their break when they walked into the resident's room to speak with the SDM, and forgot that they were not wearing a mask. The DOC also added that staff were not to be eating food while on the unit.

Sources: Interviews with RPN #101, DOC, resident #002's SDM and other staff; Directive #3 issued on April 15, 2020. [s. 229. (4)]

3. The licensee has failed to ensure that Life Enrichment Aide (LEA) #124, PSWs #127 and #151 participated in the implementation of the IPAC program.

On a day in September 2020, Inspector #653 observed that LEA #124 did not complete hand hygiene nor wear the proper PPE when they entered a resident's room that was on droplet and contact precautions. Furthermore, PSW #127 was observed cleaning the push handles of a lift machine using the aloe med wet wipes instead of the oxivir disinfectant wipes, prior to a resident transfer. PSW #151 was also observed not wearing the proper Personal Protective Equipment (PPE) during care provision to resident #009.

The DOC acknowledged that in the above mentioned observations, the staff did not participate in the implementation of the IPAC program.

Sources: Inspector #653's observations, and interviews with LEA #124, PSWs #127 and #151, and the DOC. [s. 229. (4)]

4. The licensee has failed to ensure that PSWs #154 and #155 participated in the implementation of the IPAC program.

Based on the review of the selected video clips with the DOC, on multiple occasions PSWs #154 and #155 used the same pair of gloves during care provision to resident #008. PSW #155 also placed the clean and dirty towels on the resident's overbed table, where the food and fluids were usually placed. The DOC confirmed that the PSWs did not participate in the implementation of the IPAC program, while providing care to resident #008, as observed in the video clips.

Sources: Video clips from the resident's family, and an interview with the DOC. [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 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care that sets out the

planned care for resident #007, as it related to their risk for infection.

A review of resident #007's care plan details, indicated that the focus on infection control and risk for infection was resolved in July 2019. A review of resident #007's progress notes indicated they were diagnosed with an infection in September, November 2019, March and May 2020. An interview with RPN #117 indicated that if a resident had a history of recurring infection, then it should be identified in the written plan of care including the goal to minimize and treat the infection, as well as the indicators and signs and symptoms. During the interview, the RPN reviewed resident #007's care plan details, and acknowledged that there was no written plan of care that sets out the planned care for the resident as it related to their risk for infection, from September 2019, inclusive to May 2020.

Sources: Resident #007's progress notes; written plan of care; Interview with RPN #117. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provided direct care to resident #007.

An interview with RPN #126 indicated there was a time resident #007's family complained that a PSW applied the moisturizing cream on the resident, but not on the desired area. An interview with RN #106 indicated the family's concern was cross contamination, as the PSWs applied the cream on two different areas of the body. An interview with the DOC indicated when the family brought the cream, there were no clear directions to staff on how and where to apply it. Subsequently, the Attending Physician (AP) was asked to write an order for the cream so that the home's pharmacy could provide it with clear directions to staff.

Sources: Interviews with RPN #126, RN #106, and the DOC. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the person designated by resident #007, was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A review of resident #007's progress note indicated their alteration in skin integrity was first reported to RPN #122 one evening in April 2020. An interview with RPN #122 indicated they did not notify the SDM at the time the alteration in skin integrity was first discovered. An interview with the DOC acknowledged the above mentioned information

and that resident #007's SDM was not provided an opportunity to participate in the development and implementation of the resident's plan of care, when they were not notified of the alteration in skin integrity at the time it was first discovered.

Sources: Resident #007's progress notes; Interviews with RPN #122, and the DOC. [s. 6. (5)]

4. A review of resident #007's digital prescriber's orders form indicated in August 2019, AP #125 ordered a change to the resident's medication, and the physician was to re-assess. Further review of the form did not indicate that the box for consent documentation was signed off by the nurse, as performed. A review of resident #007's progress notes did not indicate that the resident's SDM was notified of the order. Separate interviews with RPNs #117 and #122 indicated for new physician orders, the resident's SDM would be notified, and the registered staff would document by signing off on the consent box on the digital prescriber's orders form or documenting in the progress notes. During an interview, the DOC acknowledged the above mentioned information, and that resident #007's SDM was not provided an opportunity to participate in the development and implementation of the resident's plan of care, when they were not notified of the physician's order.

Sources: Resident #007's digital prescriber's orders form; Progress notes; Interviews with RPNs #117, #122, and the DOC. [s. 6. (5)]

5. The licensee has failed to ensure that resident #005's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care, as it related to a treatment.

A complaint from resident #005's SDM indicated concerns over how the home handled a change in the resident's condition. The progress notes indicated that the SDM suggested to provide a treatment for the resident, as they were showing a change in condition, and RPN #114 stated that it could not have been implemented because the resident did not have a physician order for it. In their interview with the inspector, the RPN stated they could have brought up the suggested treatment from the SDM to the physician, but did not do so, because the physician did not mention this in their conversation. The RPN did not believe that the resident had hydration concerns, however, they did not assess the resident's hydration status. The Assistant Director of Care (ADOC) mentioned that this could have also been followed up by the nursing supervisor, but was not done so in this situation.

Sources: Interviews with RPN #114, ADOC, resident #005's SDM and other staff; Resident #005's progress notes, and electronic chart. [s. 6. (5)]

6. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #007 and #008 as specified in the plan.

Resident #007's care plan indicated they required an identified number of staff for assistance with several aspects of care. Based on the review of the video clips with the DOC, on multiple occasions, the required staff assistance was not provided to resident #007 during care provision. The resident was noted to be in discomfort at times during care. The DOC confirmed that the care set out in the plan of care was not provided to resident #007, as specified in the plan, as it related to several aspects of their care.

Sources: Resident #007's care plan; Video clips from the resident's family; Interview with the DOC. [s. 6. (7)]

7. A review of resident #007's digital prescriber's orders form indicated in August 2019, AP #125 ordered a change to the resident's medication, and the physician was to re-assess. A review of resident #007's September 2019, electronic Medication Administration Record (eMAR) indicated that the last dose of medication was administered on a day in September 2019. A review of the physician's binder and the unit 's 24HR resident condition report from that time period, did not indicate any information regarding the scheduled re-assessment of resident #007's medication. An interview with AP #125 indicated when they write an order noting the physician to re-assess, once the order was transcribed, the registered staff would put it in the physician's book on the date it would be due for re-assessment. AP #125 could not recall re-assessing the medication in September 2019. During an interview, the DOC acknowledged that the care set out in the plan of care was not provided to resident #007 as specified in the plan, when their medication was not re-assessed as ordered.

Sources: Resident #007's digital prescriber's orders form; eMAR; Physician's binder; 24HR resident condition report; Interviews with AP #125, and the DOC. [s. 6. (7)]

8. Resident #008's care plan indicated that an identified number of staff were required to be present for all care. The care plan also directed staff to ensure call bell was beside the resident where they can locate it. Based on the selected video clips reviewed with the DOC, there were several occasions wherein the required number of staff was not present

when assistance was provided to resident #008. Furthermore, on one occasion, PSW #153 transferred resident #008 using the lift machine without the appropriate staff assistance, causing discomfort to the resident. A registered staff also placed the call bell in an area where the resident could not locate it, and on multiple occasions resident #008 was observed reaching their arm out for the call bell, but not being able to locate it as it was on the floor, garbage, or the bedside table. The DOC confirmed that based on the video clips, the care set out in the plan of care was not provided to resident #008 as specified in the plan.

Sources: Video clips from the resident's family; Care plan; Interview with the DOC. [s. 6. (7)]

9. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #001 and #006 as specified in the plan, related to their scheduled continence routine, due to insufficient staffing.

Resident #001's SDM forwarded a complaint regarding concerns over the home not having enough staff to implement their toileting program. The resident's care plan indicated they required assistance with continence care and were on a schedule. PSW #100 indicated that as a result of the home's shortage of PSWs, wherein they would sometimes work with only two PSWs for a total of 32 residents on a unit, it was not realistic that the staff were following the resident's schedule. PSW #145 also stated they were unable to meet resident #001's schedule as per their plan of care, due to shortage of staff.

Sources: Interviews with PSW #100, PSW #145 and other staff; Resident #001's care plan and electronic assessments. [s. 6. (7)]

10. The MLTC received a complaint related to resident #006's continence care and how they were not being met due to the home's shortage of staff.

The resident's care plan indicated they required assistance with continence care and were on a schedule. The resident stated to Inspector #760, they recalled recently wherein the staff did not provide them assistance with continence care. The resident also mentioned delays in care, resulting in them being left sitting in their soiled brief. PSW #148 stated that when they only have two PSWs working on the unit, they do not have the time to follow the resident's toileting schedule. PSW #139 also confirmed they could not follow the toileting plan, as there were days wherein they were only able to toilet the

resident once or twice during an eight hour shift.

Sources: Interviews with PSW #148, PSW #139, resident #006 and other staff; Resident #006's care plan and electronic assessments. [s. 6. (7)]

Additional Required Actions:

CO # - 006 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:
-There is a written plan of care for each resident that sets out the planned care for the resident, and clear directions to staff and others who provide direct care to the resident;
-The resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all fourteen agency PSWs who worked at the home between January 2020 to February 2020, received training as required under s. 76 (2) of the LTCHA.

As per LTCHA, 2007, s. 2 (1), "staff" in relation to a long-term care home, means persons who work at the home, including those pursuant to a contract or agreement with the licensee.

A complaint was raised by resident #001's SDM and a resident, regarding the qualifications of the agency PSWs, who worked at the home around the period of January 2020. SC #136 stated that fourteen agency PSWs did not receive any training from the home except for an hour orientation on the floor with the home's staff. The clerk was unable to provide proof of training of the fourteen agency PSWs.

Sources: Interviews with SC #136, DOC, and other staff; Records of agency staff members who worked at the home in January 2020 and February 2020. [s. 76. (2)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007 and #008's right to be treated with

courtesy and respect and in a way that fully recognized their individuality and respected their dignity, was fully respected and promoted.

Based on the video clips reviewed with the DOC, PSW #152 said inappropriate things and was not attentive to the resident during care provision. On one occasion, PSWs #152 and #127 were also observed having personal conversations while providing continence care to the resident. The DOC acknowledged that resident #007's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity, was not fully respected and promoted, as observed in the video clips.

Sources: Video clips from the resident's family, and an interview with the DOC. [s. 3. (1) 1.]

2. Based on the review of the selected video clips with the DOC, PSWs #154, #155, and #156 were observed saying and doing inappropriate things to resident #008 during care provision, and when they were in the bedroom. The DOC acknowledged that resident #008's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity, was not fully respected and promoted, as observed in the video clips.

Sources: Video clips from the resident's family, and an interview with the DOC. [s. 3. (1) 1.]

3. The licensee has failed to ensure that resident #014 and #008's right to live in a clean environment, was fully respected and promoted.

Resident #014 brought forward concerns about the home's spa room, including how they witnessed the toilet to be stained with feces. The home's policy titled "Spa Rooms Cleaning Procedure", provided direction on cleaning of the spa room's toilet including how it should be cleaned on a daily basis. During an observation in the 3 East spa room, the toilet bowl and rim were stained with feces. The ESM indicated that staff should have cleaned the toilet. The PSW observed the spa room's toilet and confirmed along with the ESM that the toilet should not have been left it in that condition.

Sources: Spa Rooms Cleaning Procedure Policy; Interviews with resident #014, the ESM, PSW #140 and other staff; An observation on 3 East spa room; Letter from resident #014 to the home. [s. 3. (1) 5.]

4. Based on the review of the selected video clips with the DOC, the following were observed on different occasions:

-During continence care provision, PSW #155 threw the dirty towel on their blanket.
-PSW #155 knocked off the resident's garbage can, causing the contents to spill on the floor, and the PSW did not clean up the garbage. RPN #157 subsequently entered the room to administer medications, briefly looked at where the garbage was, but did not clean up the garbage on the floor.
-On one occasion, pieces of garbage were on the resident's floor. PSW #155 entered the resident's room, provided continence care, and left the room without picking up the garbage from the floor.
-Following continence care provision, the linen underneath the resident was stained and was not removed by PSW #155.

The DOC acknowledged that resident #008's right to live in a clean environment was not fully respected and promoted, as observed in the video clips.

Sources: Video clips from the resident's family, and an interview with the DOC. [s. 3. (1) 5.]

5. The licensee has failed to ensure that resident #007's right to be afforded privacy in caring for their personal needs, was fully respected and promoted by PSW #152.

Based on the review of the video clips with the DOC, on four different shifts, PSW #152 provided care to resident #007 with the bedroom door wide open. The DOC acknowledged that the PSW left the door open while providing care to the resident, and further indicated that the expectation was for the PSW to close the door to maintain privacy.

Sources: Video clips from the resident's family, and an interview with the DOC. [s. 3. (1) 8.]

6. The licensee has failed to ensure that resident #001's right to participate fully in the development and implementation of their plan of care as it related to the dining seating plan, was fully respected and promoted.

A complaint was received from resident #001's SDM related to concerns over how the

resident was moved to another area of the dining room. The resident's progress notes indicated that the SDM did not consent to the table change and the resident would return back to their original seat. RPN #144 stated they would move a resident's seating plan in the dining room for reasons including allowing further ease of staff to be at a table where all residents required feeding assistance. The DOC confirmed that the nurse moved the resident without the consent of the resident or their SDM.

Sources: Interviews with the DOC, RPN #144, resident #001's SDM and other staff; Resident #001's progress notes. [s. 3. (1) 11. i.]

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 following rights of residents are fully respected and promoted:
-Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity;
-Every resident has the right to live in a safe and clean environment;
-Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs;
-Every resident has the right to participate fully in the development, implementation, review and revision of his or her plan of care, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Medication Management policy was complied with by RPN #123, for resident #008.

O. Reg. 79/10, s. 114 (2), "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home".

Based on the review of the selected video clips with the DOC, RPN #123 did not comply with the home's policy titled "Medication Management", when the RPN placed the medication on the resident's table, and left without observing ingestion of the medication.

Sources: Video clips from the resident's family; Medication Management Policy; Interview with the DOC. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The licensee has failed to ensure that every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker program that met the requirements provided for in the Regulation.

During the review of agency PSW records from January 2020 to February 2020, there were two PSWs from agency that the home could not produce certifications for. A review of the home's contract with the agency, did not specify that the PSWs sent to the home would be certified, as required under O. Reg 79/10, s. 47 (2) (a) and s. 47 (2) (b). The DOC confirmed that the two agency PSWs, who worked at the home in January 2020 and February 2020, did not have any evidence to suggest they had the certifications to perform their duties.

Sources: Interviews with the DOC and other staff; Review of all the records of agency staff members who worked at the home in January 2020 and February 2020; Review of the home's contract with the agency. [s. 47. (1)]

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 on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, (a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and (b) has provided the licensee with proof of graduation issued by the education provider, to be implemented voluntarily.

WN #11: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007 received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, when they exhibited an alteration in skin integrity.

A review of resident #007's progress note indicated their alteration in skin integrity was first reported to RPN #122 one evening in April 2020. Further review of resident progress notes and PCC assessments did not indicate that a skin assessment was completed by RPN #122. An interview with RPN #122 indicated they were unable to do the skin assessment at the time of discovering the alteration in skin integrity, due to not having enough time during the shift. Separate interviews with RN #106 and the DOC, acknowledged that resident #007 did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, at the time the alteration in skin integrity was first discovered.

Sources: Resident #007's progress notes; PCC assessments; Interviews with RPN #122, RN #106, and the DOC. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that resident #002's wound was assessed by the RD when it was deteriorating, and that changes in their plan of care were implemented.

Resident #002's SDM stated they had concerns over how the home managed the resident's wound. The resident's progress notes indicated they had developed a small wound, but a referral was not made to the RD at that time. Subsequent progress notes indicated the wound was deteriorating as per the weekly skin assessments, however, the RD did not assess and implement specific interventions for the resident's wound until it worsened. RPN #101 stated that the RD could have been more involved with the resident's wound by implementing specific interventions that could improve the healing of the wound. The RD indicated they should have been more involved in addressing the resident's wound before it deteriorated and became infected.

Sources: Interviews with the RD, RPN #101, resident #002's SDM and other staff; Resident #002's progress notes and electronic assessments. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #008 was provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Based on the review of the selected video clips with the DOC, on several occasions, PSWs brought the meal tray inside the resident's room, placed it on the overbed table, without waking up the resident, nor repositioning the resident to be upright in bed. On one occasion, PSW #156 delivered the meal tray, placed it on the overbed table, and left the room without turning the lights on. A registered staff was also observed administering the resident's medication and providing a drink, with the resident lying supine on the bed, and not adjusting the head of the bed. The DOC confirmed that based on the video clips, resident #008 was not provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Sources: Video clips from the resident's family, and an interview with the DOC. [s. 73. (1) 9.]

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, the following elements: Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated and resolved where possible, and where the complaint alleged harm or risk of harm to one or more residents, the investigation commenced immediately.

The Executive Director (ED) received a forwarded written complaint from a resident's family, outlining concerns related to injuries from unknown cause, improper transfer, outdated care plan, wound mismanagement, infection control practices, medication errors, delegation of cream application, and the resident’s personal health information not

kept confidential. Six days later, the ED provided an acknowledgment of receipt and that the home requested an outside resource to conduct a fulsome review of the identified issues. Interviews with the ED and the DOC indicated the Extendicare LTC Consultant conducted the investigation on the written complaint. Interviews with the DOC and the Consultant indicated that the family member alleged risk of harm based on their outlined concerns in the written complaint. An interview with the Consultant indicated they were asked by their superior to do the chart audit report, as part of the thorough investigation of the written complaint, to help the ED to respond to the Board Chair and identify any gaps. The consultant further indicated they did not investigate on the infection control practices, medication errors, and the resident's personal health information not kept confidential by the ED, because they were not on-site a the home. The DOC acknowledged that an investigation did not commence immediately, with regards to the family's written complaint wherein they alleged risk of harm to the resident.

Sources: Resident's family’s written complaint; The home’s written response; Interviews with the ED, DOC, and the Extendicare LTC Consultant. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a response was made to the person who made the complaint, indicating what the licensee has done to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief.

The Consultant sent the final report to the home, and the DOC confirmed that the family had not received the response, and that they were planning to provide the update in the next few weeks.

Sources: Resident’s family’s written complaint, the home’s written response, e-mail correspondence with the DOC, and an interview with Extendicare LTC Consultant. [s. 101. (1) 3.]

3. The licensee has failed to ensure that the documented record of complaints received, was reviewed and analyzed for trends, at least quarterly.

During an interview, the ED reviewed the home’s record of complaints analysis, and confirmed that the last review and analysis for trends was done in April 2019, for the complaints received for the months of January, February, and March 2019.

Source: Interview with the ED. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure:
-That every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
-That the documented record is reviewed and analyzed for trends at least quarterly, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of resident #007's progress notes from three different days in April 2020, indicated documentations from the Nurse Practitioner, (NP), RN #137, and the Medical Director, that the family member was concerned regarding the alteration in skin integrity, and was alleging trauma/ abuse. An interview with RN #137 indicated they relayed the allegation to the ADOC, as documented in the progress note. An interview with the DOC confirmed that the allegation of abuse was not immediately reported to the Director.

Sources: Resident #007's progress notes; Interviews with RN #137, and the DOC. [s. 24. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of a resident's continence, including bowel elimination.

A review of a resident's POC look back report on bowel elimination, and the resident's clinical and order alerts listing report for July 2020, indicated that the resident did not have regular BMs.

During separate interviews, AP #125 and the RD reviewed the resident's POC look back report on bowel elimination, and the resident's clinical and order alerts listing report for July 2020, and both acknowledged they were not notified of the resident having problems with constipation. During an interview, the DOC acknowledged that the resident's plan of care was not based on, at a minimum, an interdisciplinary assessment of the resident's bowel elimination.

Sources: Resident's POC look back report; Clinical and order alerts listing report; Interviews with AP #125, RD, and the DOC. [s. 26. (3) 8.]

2. The licensee has failed to ensure that resident #007's plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's disease diagnosis.

A review of resident #007's progress note from November 2018, indicated RPN #117 had spoken to the resident's family member, and stated to them that they would have the physician assess the resident's disease diagnosis. A review of progress note from February 2020, indicated RPN #117 was reminded by the resident's family member about the disease diagnosis that the resident has had for years. A review of resident #007's PCC medical diagnoses, care plan, and their current problem list in the chart, did not identify any information regarding the disease diagnosis. An interview with AP #125 indicated that if further information regarding a resident's disease diagnosis was brought to their attention, they would normally write an order to add the disease diagnosis to the resident's profile. During the interview, AP #125 and Inspector #653 reviewed RPN #117's documentation and indicated they could not recall that time period, however, confirmed that the disease diagnosis was not included in the resident's disease diagnoses on PCC and current problem list.

Sources: Resident #007's progress notes; PCC medical diagnoses; Care plan; Current problem list; Interview with AP #125. [s. 26. (3) 9.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006 received fingernail care, including the cutting of fingernails, due to shortage of staff.

The MLTC received concerns regarding how staff were not cutting resident #006's fingernails. The resident's care plan indicated they were to get their fingernails trimmed and cleaned on the first bath of each month. A review of the POC documentation did not indicate that staff provided nail care to the resident for one month. The resident stated in an interview, that their nails were cut by their family member. The resident could not recall the last time their nails were cut by a staff member of the home. PSW #139 stated they have never trimmed the resident's fingernails and had observed the resident's nails to be dirty and long, but only soaked them in water when this was noticed. PSW #148 indicated that they last trimmed the resident's fingernails about three weeks prior, but there had been times they could not trim the resident's nails even though it was in an unkempt manner because of the shortage of staff on the floor.

Resources: Interviews with PSW #139, PSW #148 and other staff; The resident's care plan; POC documentation; Policy of the home titled: Nail and Foot Care. [s. 35. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the shower tub was cleaned and disinfected on unit 3 West.

Resident #014 brought forward concerns related to the housekeeping services at the home, including the spa room. The home's policy indicated that the spa rooms were to be cleaned on a daily basis. During an observation in the 3 West spa room, the bath tub was stained with grime. The ESM stated that the stains appeared old, and that the PSWs were supposed to clean the tub after each use and housekeeping staff would do a deep clean afterwards. The ESM further stated that if the PSWs did not have time to clean the tub, they could always get other staff to help out. PSW #139 observed the spa room on 3 West and confirmed it was not clean, and would have reported this observation to the nurse, had they noticed it prior to giving a resident a bath.

Sources: Spa Rooms Cleaning Procedure Policy; Interviews with ESM, PSW #139 and other staff and resident #014; An observation on 3 West spa room; Letter from resident #014 to the home. [s. 87. (2) (b)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002’s linens were changed as needed.

Resident #002’s SDM brought forward concerns over how they witnessed the resident sitting in stained linen. The DOC provided a picture of the stain to Inspector #760. RPN #101 indicated they did not see the stain when they changed the resident on the day of, because there was a blue pad between the resident and the linen. The RPN Student provided continence care to the resident that day, and did not check if there were any stains on the linen. The student nurse stated if they saw the stain, they would have changed the bed linen.

Sources: Interviews with RPN #101, RPN Student, resident #002’s SDM and other staff; picture of the stain shown to inspector by the DOC. [s. 89. (1) (a) (i)]

2. The licensee has failed to ensure that resident #001's clothing were labelled within 48 hours of acquisition in December 2019, due to shortage of staff in the laundry department.

Resident #001's SDM indicated it took two and a half weeks for the resident's new clothing to be labeled during Christmas time in 2019. PSW #100 stated they were working in the laundry department at that time, and it took several days to have clothing items labelled, because there was a shortage of staff working in the laundry department. The PSW indicated that the focus was on washing the linens and essential items rather than labeling clothing items that were newly brought in. The ESM confirmed that the home's shortage of staff contributed to the delay of having clothing items labelled and returned to the residents of the home, during the period of December 2019.

Sources: Interviews with resident #001's SDM, PSW #100, ESM and other staff. [s. 89. (1) (a) (ii)]

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

Issued on this 8th day of October, 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) :	ROMELA VILLASPIR (653), JACK SHI (760)
Inspection No. / No de l'inspection :	2020_748653_0016
Log No. / No de registre :	001285-20, 001645-20, 002715-20, 003474-20, 007689-20, 010577-20, 011699-20, 015783-20, 017198-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 2, 2020
Licensee / Titulaire de permis :	Southlake Residential Care Village 690 Grace Street, NEWMARKET, ON, L3Y-8V7
LTC Home / Foyer de SLD :	Southlake Residential Care Village 640 Grace Street, NEWMARKET, ON, L3Y-8V7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anne Deelstra

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

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee must:

1. Review the grounds of Compliance Order (CO) #001 with the full-time and part-time Personal Support Workers (PSWs) and registered staff from all shifts, who are primarily assigned to resident #008's care.

2. Develop and implement a monitoring process to ensure that resident #008 is free from abuse and neglect.

3. A record is required to be kept by the licensee for all actions undertaken in items #1 to #2. The record shall be made available to the inspector upon request.

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 resident #008 was protected from abuse and free from neglect by the staff in the home.

Based on separate interviews with resident #008 and the Director of Care (DOC), and a review of selected video clips, it was noted that the resident was abused and neglected by three Personal Support Workers (PSWs).

Sources: Video clips from the resident's family, and interviews with resident #008 and the DOC.

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

Severity: Resident #008 was verbally and emotionally abused, neglected by the three PSWs on multiple occasions. There was actual risk of harm to the resident because the incidents of abuse and neglect towards the resident, involving the same PSWs, took place on multiple occasions.

Scope: The scope of this non-compliance was isolated as no other incidents of abuse and neglect were identified during this inspection.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s. 19 (1) of the LTCHA, and two Written Notifications (WNs) and two Voluntary Plan of Corrections (VPCs) were issued to the home. (653)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 11, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Specifically, the licensee must prepare, submit, and implement a plan to ensure that the staffing plan include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work. The plan must include but is not limited to:

1. A back-up plan for nursing and personal care staffing where it will specifically address how the home will continue to meet the assessed needs of residents in the home when there is a staffing shortage.

2. What constitutes as a staffing shortage and when the back-up plan will be utilized.

3. The back-up plan will include the roles of each staff member and their tasks, in order to meet the resident's assessed care needs.

4. How the licensee will recruit and retain staff who provide nursing and personal support services in order to meet the assessed care needs of residents.

5. A record is required to be kept by the licensee for all actions undertaken in items #1 to #4. The record shall be made available to the inspector upon request.

Please submit the written plan for achieving compliance for inspection #2020_748653_0016 to Jack Shi, LTC Homes Inspector, MLTC, by October 26, 2020.

Please ensure that the submitted written plan does not contain any Personal Information (PI)/ Personal Health Information (PHI).

Grounds / Motifs :

1. The licensee has failed to ensure that there was a back-up plan for nursing and personal care staffing that specifically addressed situations where the home did not have enough staff to come to work.

The Ministry of Long-Term Care (MLTC) received four complaints from the Substitute Decision-Makers (SDMs), and family council regarding the home not having sufficient staffing levels to meet the care needs of the residents. The home's written staffing shortage plan reviewed in 2020, did not specifically address what would constitute as a staffing shortage, and how the home would meet the care needs of the residents in the event that the home had insufficient staff working on-site.

On a day in August 2020, there were 11 PSW shifts vacant. The home was not able to find replacement PSWs to come in to work, so the managers were called in to assist. Registered Nurse (RN) #106, who worked that shift, stated that some of the managers and additional staff members who came in that day were not trained in providing care to residents, and thus they were only helping out with certain tasks like feeding and portering. The DOC confirmed that the home's staffing back-up plan indicated that in the event they did not have enough staff to provide care to residents, the home would have all hands-on deck. However, it was not specific in describing how the care needs of residents would be met, as experienced by the home on a day in August 2020.

In addition, the Human Resources (HR) stated the home was currently close to a critical level in the shortage of staff, and the home has contacted three agency companies to provide more PSWs to work in the home. The DOC indicated the agency companies currently used by the home were not effective at providing additional PSWs to work at the home. The DOC also mentioned they were unsure that the home's current contingency plan was effective, and it would be difficult for the home to manage a second wave of COVID-19.

Sources: Review of records of staff who worked on a day in August 2020; the home's written staffing shortage plan last reviewed in 2020; Interviews with the DOC, HR, ESM, RN, Scheduling Clerks (SCs) and other staff, residents, and SDMs.

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

Severity: There were minimal discomfort and minimal risk of harm to the residents, resulting from the home not having a back-up plan for nursing and personal care that specifically addressed situations wherein the home did not

have enough staff to come to work and did not provide a staffing mix that met the resident's assessed needs.

Scope: The scope of this non-compliance was widespread because the insufficient staffing problems affected all the units.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10 s. 31 (3), and one WN and one VPC were issued to the home. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 08, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 003

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

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 s. 36 of O. Reg. 79/10.

Specifically, the licensee must:

1. Review the following with the full-time and part-time PSWs and registered staff from all shifts, who are primarily assigned to resident #009, #007, and #008's care:
-Grounds of Compliance Order (CO) #003;
-Proper operation of the required lift machine for the above mentioned residents.

2. Document the review, including the date, attendees, and the staff member who facilitated the review.

3. A record is required to be kept by the licensee for all actions undertaken in items #1 to #2. The record shall be made available to the inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that PSW #149 used safe transferring devices or techniques when they assisted resident #009.

A review of progress notes indicated on one occasion, PSW #149 transferred the resident without using the required lift machine and staff assistance. Separate interviews with Registered Practical Nurse (RPN) #115 and the DOC, indicated that resident #009 sustained an injury as a result of the unsafe transfer.

Sources: Resident #009's care plan; Point Click Care (PCC) progress notes; Interviews with RPN #115 and the DOC. (653)

2. The licensee has failed to ensure that PSW #152 used safe transferring techniques when they assisted resident #007.

Based on the review of the video clips and an interview with the DOC, on two different shifts, PSW #152 transferred resident #007 using the lift machine without the appropriate staff assistance. The DOC confirmed that PSW #152 did not use safe transferring techniques when they assisted resident #007, as observed in the video clips.

Sources: Video clips from the resident's family, and an interview with the DOC. (653)

3. The licensee has failed to ensure that PSWs #153 and #154 used safe transferring and positioning techniques when they assisted resident #008.

Based on the review of the selected video clips and an interview with the DOC, PSW #153 transferred resident #008 using the lift machine without the appropriate staff assistance, causing discomfort to the resident. In addition, PSW #154 was observed using unsafe positioning techniques when they assisted resident #008 in bed, causing discomfort to the resident. The DOC confirmed that PSWs #153 and #154 did not use safe transferring and positioning techniques when they assisted resident #008, as observed in the video clips.

Sources: Video clips from the resident's family, and an interview with the DOC.

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

Severity: There was actual harm to resident #009 as they sustained a fracture, and actual risk of harm to residents #007 and #008, as a result of the use of unsafe transfer and positioning techniques.

Scope: The scope of this non-compliance was widespread, as the unsafe transfers were carried out by the PSWs for three of the three residents reviewed

during the inspection.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 11, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

1. Ensure that all registered staff are trained on the home's hydration policy so that the Nursing Hydration Assessment form is completed and actions are taken with respect to resident requirements.

Grounds / Motifs :

1. The licensee has failed to ensure that the hydration program included the implementation of interventions to mitigate and manage the identified risks related to hydration.

A review of the home's policy, titled "Food and Fluid Intake Monitoring", revealed that if a resident did not meet their individualized fluid target for three

consecutive days, the nurse must complete a Nursing Hydration Assessment. The home's Registered Dietitian (RD) also indicated that a fluid serving was considered a cup or 125 milliliters (mls).

Resident #005's SDM forwarded a complaint related to the home's interventions when the resident had a change in condition. The resident's care plan indicated they had a fluid target goal, and required monitoring of their hydration status. The resident's progress notes indicated on a day in July 2020, the resident had a change in condition, and was not taking in their fluids despite staff encouragement. A review of the resident's fluid intake, indicated they did not meet their fluid target goal on the day they had a change in condition, and two days prior. RPN #114 stated they were unaware of what a hydration assessment was and where to find a resident's daily fluid servings, thus, this was not done for the resident when they had a change in condition. The resident was subsequently sent to the Emergency at the hospital for treatment.

Sources: Interviews with RPN #114, resident #005's SDM and other staff; resident #005's progress notes, daily fluid intake and plan of care; Food and Fluid Intake Monitoring Policy. (760)

2. Resident #002's SDM brought forward a complaint related to how the home managed the resident's hydration needs. RPN #101 indicated the resident was at nutritional risk and had a fluid target goal. For a period of one month, the resident was not meeting their fluid target goal. A review of the electronic assessments did not show that a hydration assessment was completed during this period. PSW #100 mentioned that the night shift PSW used to calculate the residents' total daily fluid intake, and would inform the day shift to push fluids for residents that did not have a total of 1500 mls daily, however, this practice was stopped a while ago due to short staffing. RPN #101 stated they did not have a process in place to monitor this resident's fluid intake and would only do a hydration assessment, if a PSW stated to them that the resident was not drinking.

Sources: Interviews with RPN #101, PSW #100, resident #002's SDM and other staff; resident #002's plan of care, daily fluid intake and electronically documented assessments; Food and Fluid Intake Monitoring Policy. (760)

3. A review of resident #007's PCC physician order and an interview with the RD, indicated they were at nutritional risk and had a fluid target goal.

A review of the Point of Care (POC) fluid look back report for the months of May, June, and July, 2020, revealed that the resident only met their fluid target goal three times in June, and twice in July.

A review of PCC assessments indicated the last Clinical – Hydration Assessment completed by the registered staff for reduced fluid intake was in March 2019.

Separate interviews with RPNs #117, #123, and #129, indicated that previously, the night registered staff calculated the residents' daily fluid intake, and those who did not meet their fluid goals would be flagged to the day registered staff, and a hydration assessment would be completed. RPNs #117 and #123 confirmed that this practice had not been done this year.

Separate interviews with the Food Service Supervisor (FSS), Food Service Manager (FSM), RD, and the DOC, confirmed that resident #007's fluid intake was not being calculated by the registered staff, and that a hydration assessment was not completed, when they did not meet their individualized fluid target for three consecutive days, numerous times, in May, June, and July 2020.

Sources: PCC physician order; POC fluid look back report; PCC assessments; Interviews with RPNs #117, #123, #129, FSS, FSM, RD, and the DOC.

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

Severity: There was actual risk of harm to the residents at high nutritional risk, because the hydration program did not include the implementation of interventions to mitigate and manage the residents' identified risks related to hydration.

Scope: The scope of this non-compliance was widespread because the implementation of interventions to mitigate and manage the identified risks related to hydration, was not completed for three of the three residents reviewed

during the inspection.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 11, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 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 compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Review the grounds of Compliance Order #005 with the staff identified in the grounds, who are still employed in the home.

2. Train the identified staff from item #1 and the full-time, and part-time PSWs and registered staff from all shifts, who are primarily assigned to resident #009, #007, #008's care, on the home's Infection Prevention and Control (IPAC) program that includes:
-hand hygiene;
-the use of personal protective equipment;
-cleaning and disinfection of resident lift machines;
-proper disposal of soiled briefs and used towels and;
-placement of the wound treatment cart when in use.

3. Document the training, including the date, attendees, and the staff member who provided the training.

4. Develop and implement an auditing system for the home's IPAC program, to ensure staff adhering to the IPAC program until full compliance.

5. A record is required to be kept by the licensee for all actions undertaken in items #1 to #4. The record shall be made available to the inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that PSW #152 and RPN #101 participated in the implementation of the Infection Prevention and Control (IPAC) program.

Based on the review of the video clips with the DOC, PSW #152 did not participate in the implementation of the IPAC program when providing care to resident #007. Furthermore, it was also observed that RPN #101 brought the wound treatment cart inside the resident's room, instead of leaving it outside, by the door. The DOC confirmed that PSW #152 and RPN #101 did not participate in the implementation of the IPAC program, as observed in the video clips.

Sources: Video clips from resident #007's family, and an interview with the DOC. (653)

2. The licensee has failed to ensure that RPN #101 participated in the implementation of the IPAC program, as it related to wearing a mask while interacting with resident #002 and their SDM.

Resident #002's SDM brought forward a complaint related to a visit at the home in August 2020, wherein they noticed RPN #101 entered the resident's room without a mask on, as they were eating. Under the LTCHA, Directive #3 was issued on April 15, 2020, which required all LTC staff to wear a surgical mask at all times. The RPN stated they were on their break when they walked into the resident's room to speak with the SDM, and forgot that they were not wearing a mask. The DOC also added that staff were not to be eating food while on the unit.

Sources: Interviews with RPN #101, DOC, resident #002's SDM and other staff; Directive #3 issued on April 15, 2020. (760)

3. The licensee has failed to ensure that Life Enrichment Aide (LEA) #124, PSWs #127 and #151 participated in the implementation of the IPAC program.

On a day in September 2020, Inspector #653 observed that LEA #124 did not complete hand hygiene nor wear the proper PPE when they entered a resident's room that was on droplet and contact precautions. Furthermore, PSW #127 was observed cleaning the push handles of a lift machine using the aloe med wet wipes instead of the oxivir disinfectant wipes, prior to a resident transfer. PSW

#151 was also observed not wearing the proper Personal Protective Equipment (PPE) during care provision to resident #009.

The DOC acknowledged that in the above mentioned observations, the staff did not participate in the implementation of the IPAC program.

Sources: Inspector #653's observations, and interviews with LEA #124, PSWs #127 and #151, and the DOC. (653)

4. The licensee has failed to ensure that PSWs #154 and #155 participated in the implementation of the IPAC program.

Based on the review of the selected video clips with the DOC, on multiple occasions PSWs #154 and #155 used the same pair of gloves during care provision to resident #008. PSW #155 also placed the clean and dirty towels on the resident's overbed table, where the food and fluids were usually placed. The DOC confirmed that the PSWs did not participate in the implementation of the IPAC program, while providing care to resident #008, as observed in the video clips.

Sources: Video clips from the resident's family, and an interview with the DOC.

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

Severity: There was actual risk of harm to the residents, when the staff did not participate in the implementation of the IPAC program, during interaction and care provision.

Scope: The scope of this non-compliance was a pattern because the occurrence was in several locations, and the same residents have been affected by repeated occurrences of the same deficient practice.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s. 229 (4) of O. Reg. 79/10, and two WNs and one VPC were issued to the home. (653)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jan 11, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

The licensee must ensure that the care set out in the plan of care for residents #001, #006, #007, and #008, is provided to the residents.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #007 and #008 as specified in the plan.

Resident #007's care plan indicated they required an identified number of staff for assistance with several aspects of care. Based on the review of the video clips with the DOC, on multiple occasions, the required staff assistance was not provided to resident #007 during care provision. The resident was noted to be in discomfort at times during care. The DOC confirmed that the care set out in the plan of care was not provided to resident #007, as specified in the plan, as it related to several aspects of their care.

Sources: Resident #007's care plan; Video clips from the resident's family; Interview with the DOC. (653)

2. A review of resident #007's digital prescriber's orders form indicated in August 2019, AP #125 ordered a change to the resident's medication, and the physician was to re-assess. A review of resident #007's September 2019, electronic Medication Administration Record (eMAR) indicated that the last dose of medication was administered on a day in September 2019. A review of the physician's binder and the unit's 24HR resident condition report from that time period, did not indicate any information regarding the scheduled re-assessment

of resident #007's medication. An interview with AP #125 indicated when they write an order noting the physician to re-assess, once the order was transcribed, the registered staff would put it in the physician's book on the date it would be due for re-assessment. AP #125 could not recall re-assessing the medication in September 2019. During an interview, the DOC acknowledged that the care set out in the plan of care was not provided to resident #007 as specified in the plan, when their medication was not re-assessed as ordered.

Sources: Resident #007's digital prescriber's orders form; eMAR; Physician's binder; 24HR resident condition report; Interviews with AP #125, and the DOC. (653)

3. Resident #008's care plan indicated that an identified number of staff were required to be present for all care. The care plan also directed staff to ensure call bell was beside the resident where they can locate it. Based on the selected video clips reviewed with the DOC, there were several occasions wherein the required number of staff was not present when assistance was provided to resident #008. Furthermore, on one occasion, PSW #153 transferred resident #008 using the lift machine without the appropriate staff assistance, causing discomfort to the resident. A registered staff also placed the call bell in an area where the resident could not locate it, and on multiple occasions resident #008 was observed reaching their arm out for the call bell, but not being able to locate it as it was on the floor, garbage, or the bedside table. The DOC confirmed that based on the video clips, the care set out in the plan of care was not provided to resident #008 as specified in the plan.

Sources: Video clips from the resident's family; Care plan; Interview with the DOC. (653)

4. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #001 and #006 as specified in the plan, related to their scheduled continence routine, due to insufficient staffing.

Resident #001's SDM forwarded a complaint regarding concerns over the home not having enough staff to implement their toileting program. The resident's care plan indicated they required assistance with continence care and were on a schedule. PSW #100 indicated that as a result of the home's shortage of PSWs,

wherein they would sometimes work with only two PSWs for a total of 32 residents on a unit, it was not realistic that the staff were following the resident's schedule. PSW #145 also stated they were unable to meet resident #001's schedule as per their plan of care, due to shortage of staff.

Sources: Interviews with PSW #100, PSW #145 and other staff; Resident #001's care plan and electronic assessments. (760)

5. The MLTC received a complaint related to resident #006's continence care and how they were not being met due to the home's shortage of staff.

The resident's care plan indicated they required assistance with continence care and were on a schedule. The resident stated to Inspector #760, they recalled recently wherein the staff did not provide them assistance with continence care. The resident also mentioned delays in care, resulting in them being left sitting in their soiled brief. PSW #148 stated that when they only have two PSWs working on the unit, they do not have the time to follow the resident's toileting schedule. PSW #139 also confirmed they could not follow the toileting plan, as there were days wherein they were only able to toilet the resident once or twice during an eight hour shift.

Sources: Interviews with PSW #148, PSW #139, resident #006 and other staff; Resident #006's care plan and electronic assessments.

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

Severity: There were minimal discomfort and minimal risk of harm to the residents, resulting from the care set out in the plan of care not provided to residents #007, #008, #001, and #006 as specified in the plan.

Scope: The scope of this non-compliance was widespread because the care set out in the plan of care, was not provided to four of the four residents reviewed during the inspection.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s. 6 (7) of the LTCHA, and 7 WNs and 5 VPCs were issued to the home. (760)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 11, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 007

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee must be compliant with s. 76 (2) of the LTCHA.

Specifically, the licensee must:

1. Provide training to all agency staff prior to them performing their responsibilities in the home, in the areas mentioned in s. 76 (2).

2. Maintain the training records of all agency staff.

Grounds / Motifs :

1. The licensee has failed to ensure that all fourteen agency PSWs who worked at the home between January 2020 to February 2020, received training as required under s. 76 (2) of the LTCHA.

As per LTCHA, 2007, s. 2 (1), "staff" in relation to a long-term care home, means persons who work at the home, including those pursuant to a contract or agreement with the licensee.

A complaint was raised by resident #001's SDM and a resident, regarding the qualifications of the agency PSWs, who worked at the home around the period of January 2020. SC #136 stated that fourteen agency PSWs did not receive any training from the home except for an hour orientation on the floor with the home's staff. The clerk was unable to provide proof of training of the fourteen agency PSWs.

Sources: Interviews with SC #136, DOC, and other staff; Records of agency staff members who worked at the home in January 2020 and February 2020.

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

Severity: There was minimal risk of harm to the residents, when the fourteen agency PSWs did not receive training as required under s. 76 (2) of the LTCHA.

Scope: The scope of this non-compliance was widespread because all the PSWs from a particular agency, that the home utilized, did not receive the required training.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 08, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

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

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 2nd day of October, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

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