Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Amended Public Copy/Copie modifiée 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
Jun 17, 2020	2019_560632_0020 (A3)	016112-19, 016753-19	Complaint

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 HAMILTON ON L8N 4A6

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

St. Joseph's Villa, Dundas
56 Governor's Road DUNDAS ON L9H 5G7

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

Amended by STACEY GUTHRIE (750) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

See extension of Compliance Due Date for r. 31(3) to October 31, 2020.

Issued on this 17th day of June, 2020 (A3)

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

Original report signed by the inspector.

Ontario

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

Amended by STACEY GUTHRIE (750) - (A3)

Amended 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 20, 21, 22, 23, 26, 27, 28, 29, 30, September 3, 4, 5, 6, 10, 11, 12, 13, 16, 17, 24, 25, 26, 27, 2019.

The following Complaint inspections were completed:

log #016112-19 - related to sufficient staffing, responsive behaviors, falls prevention, medications, nutrition and hydration, personal support services, hospitalization and change in condition;

log #016753-19 - related to nutrition and hydration, personal support services, sufficient staffing.

The following Critical Incident System Inspection (CIS) #2019_558123_0011 was completed concurrently with the Complaint Inspection:

log #015523-19 - related to unusual death.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC) #101, DOC #107, Assistant Director of Care (ADOC), Food Service Supervisor (FSS) #1, FSS #2, Charge Nurse, Resident Assessment Instrument (RAI) Co-ordinator, Staffing Supervisor, Staffing Clerk, Chief Steward CUPE 1404, Infection Control, dietary aids (DA), Physiotherapist (PT), Executive Assistant, Wound Care Nurse, personal support workers (PSWs), registered nurses (RNs), registered practical nurses (RPNs), residents and their families.

During the course of the CIS inspection, the inspector(s) reviewed clinical records, policies, procedures, and practices within the home, reviewed meeting minutes, staff education and programs evaluation records, investigation notes, observed the provision of care and medication administration.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
10 WN(s)
4 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

Complaint log #016112-19 (IL-69390-HA), submitted to the Ministry of Long-Term Care (MOLTC), identified concerns related to staffing shortage in the home affecting residents' care, was reviewed.

On an identified date in September 2019, LTC Home Inspector #632 observed care provided to residents in an identified home area. During the observation, one PSW was available on the home area when three residents requested to go to the bathroom. The following observations were made related to safe transferring:

A. Resident #012 was transferred and provided toileting assistance by one PSW. In an interview with PSW #163 it was confirmed that the plan of care directed staff to provide two person assistance with toileting and transfers.

Review plan of care for resident #012 indicated that the resident required assistance by two staff for toileting and transferring. Physiotherapy assessment indicated that the resident needed two person specified assist for all surfaces.

Review of the home's "Resident handling: lifts, transfers and repositioning" policy indicated that that staff in the home adhered to designated lift and/or transfer status as identified on each resident's care plan and/or Kardex and/or resident lift.

During the inspection the Administrator indicated that the assistance with the transfers was to be provided by the registered staff if the second PSW staff was not available.

The licensee failed to ensure that staff used safe transferring and positioning techniques techniques, when assisting resident #012.

B. Resident #014 was transferred and provided toileting assistance by one PSW. In an interview with PSW #163 it was confirmed that the plan of care directed staff to provide two person assistance with toileting and transfers.

Review plan of care for resident #014 indicated that the resident required assistance by two staff and the use of specified assistive device for transfer and toileting. Physiotherapy assessment indicated that the resident needed two person assist using another specified device for all surfaces' specified activity.

Review of the home's "Resident handling: lifts, transfers and repositioning" policy indicated that staff in the home adhered to the designated lift and/or transfer status as documented on each resident's care plan and/or Kardex and/or resident's specified support.

During the inspection the Administrator indicated that the assistance with the transfer was to be provided by the registered staff if the second PSW staff was not available.

The licensee failed to ensure that staff used safe transferring and positioning techniques techniques, when assisting resident #014.

C. Resident #067 was transferred and provided toileting assistance by one PSW #163. In an interview with PSW #163 it was confirmed that the plan of care directed staff to provide two person assistance with toileting and transfers.

Review plan of care for resident #067 indicated that the resident required assistance by two staff for toileting and transferring. Physiotherapy assessment indicated that the resident needed two person assist for all surfaces.

Review of the home's "Resident handling: lifts, transfers and repositioning" policy indicated that staff in the home adhered to the designated lift and/or transfer status as documented on each resident's care plan and/or Kardex and/or resident's specified support.

During the inspection staff #109 confirmed that on an identified date in September 2019, there was a float PSW staff missed during day shift in an identified home area.

During the inspection the Administrator indicated that the assistance with the transfer was to be provided by the registered staff if the second PSW staff was not available.

The licensee failed to ensure that staff used safe transferring and positioning techniques techniques, when assisting resident #067. [s. 36.]

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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered (a) a minimum of three meals daily.

A. Review of Food and Fluid Intake forms indicated that on an identified date in June 2019, no breakfast was provided to resident #027 in an identified home area and it was coded as "SL" sleeping.

Review of the current written care plan identified that resident #027 was at

nutrition risk and it was indicated to offer a specified amount of fluids at meals to the resident. Specified intervention were identified if the resident demonstrated an identified behaviour.

During the inspection, PSW #169 indicated that on a specified date in June 2019 resident #027 demonstrated the known behaviour.

The licensee failed to ensure that on the identified date in June 2019 resident #027 was offered (a) breakfast.

B. Complaint log #016753-19 (IL-69698-HA), submitted to the MOLTC, identified concerns related to staffing shortage in the home affecting resident's care.

Review of Food and Fluid intake forms indicated that on an identified date in August 2019, no breakfast was provided to residents' #010, #028, #029, #030, #032 and #034 in an identified home area.

Review plan of care identified that the residents were all at nutritional risk.

During the inspection, PSW #133 indicated that on an identified date, the home area was missing two PSWs for a period of time during the shift and the residents remained in bed and were not provided assistance to get to the dining room due to staffing shortage.

The licensee failed to ensure that on an identified date in August 2019, residents' #010, #028, #029, #030, #032 and #034 in an identified home area were offered (a) a minimum of breakfast. [s. 71. (3) (a)]

2. The licensee failed to ensure that each resident was offered a minimum of (b) a between-meal beverage in the morning.

Complaint log #016112-19 (IL-69390-HA) submitted to the MOLTC, identified concerns related to staffing shortage in the home affecting residents' care, was reviewed.

A. Review Food and Fluid Intake forms indicated that on an identified date in June 2019, no nourishments were provided to 17 residents (including residents' #011, #012, #013, #014, #015, #016, #017, #018, #019, #020, #021, #022, #023, #024, #025, #026 and #027) at specified period of the day in an identified home area.

Review plan of care identified that the residents were all at nutritional risk.

During the inspection, PSW #169, indicated that on an identified date, an identified home area was missing one PSW staff and there was no time to give nourishments to the residents at the scheduled nourishment time.

The licensee failed to ensure that on an identified date in June 2019, residents' #011, #012, #013, #014, #015, #016, #017, #018, #019, #020, #021, #022, #023, #024, #025, #026 and #027 in an identified home area were offered a minimum of (b) a between-meal beverage at specified period of the day.

B. Review of Food and Fluid Intake forms indicated that on an identified date in July 2019, no nourishments were provided to residents' #035, #036, #037, #038, #039, #040, #041, #042, #043, #044, #045, #046, #047, #048 and #049 in an identified home area at specified period of the day.

Review plan of care identified that the residents were all at specified nutritional risk.

During the inspection PSW #170 indicated that on an identified date, an identified home area was missing one PSW staff and there was no time to give nourishments to the residents at the scheduled nourishment time.

The licensee failed to ensure that on an identified date in July 2019, residents' #035, #036, #037, #038, #039, #040, #041, #042, #043, #044, #045, #046, #047, #048 and #049 in an identified home area were offered a minimum of (b) a between-meal beverage at specified period of the day.

C. Review of Food and Fluid intake forms indicated that on an identified date in August 2019, no nourishments at specified period of the day were provided to residents' #010, #028, #029, #030, #031, #032, #033 and #034 in an identified home area.

Review of the plan of care identified that resident #010, #028, #029, #030, #031, #032, #033 and #034 were all assessed to be at nutritional risk.

During the inspection PSW #133 indicated that on an identified date, an identified home area was missing two PSWs staff and no nourishments were provided to

the residents due to the staffing shortage.

The licensee failed to ensure that on an identified date in August 2019, residents' #010, #028, #029, #030, #031, #032, #033 and #034 in an identified home area were offered a minimum of (b) a between-meal beverage at the specified period of the day. [s. 71. (3) (b)]

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. 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 failed to ensure that the home's staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation.

Complaint log #016112-19 (IL-69390-HA), received by the MOLTC, was reviewed. It alleged that from May to August 2019, there was ongoing nursing department staffing shortages in the home affecting resident care.

St. Joseph's Villa is a Long-Term Care Home (LTCH) with a licensed capacity of 425 beds. The licensee used a "Nursing Department Staffing – updated May 7, 2019", which had a staffing mix over a 24 hours (hrs) period.

During the inspection, the DOC #107 provided to Inspector #632 Staffing Plan-St. Joseph's Villa Long-Term Care, which contained staff planning (shift start/end, days per week, etc.) by department. In the documentation provided by the Administrator it was indicated that in November 2017, additional PSWs' hours to 2 North and 4 South were added. The goal of these hours is to ensure that the units have 3 PSWs on the floors, during the busiest time each morning. "We are pleased to announce that we will be adding additional PSWs' hours to 2 South and 3 South... These hours are temporary at present, but we will reassess this in the New Year, and determine a fulsome plan".

During the inspection, the Administrator provided to Inspectors' #123 and #632 CUPE 1404 Workload Review forms (for an identified period from May to August 2019), submitted by the home's employees to their union. Review of the forms identified that out of the total of 43 submitted concerns, there were 21 concerns related to personal care staffing shortages in the home that affected the residents' care. Also, there were six concerns related to registered staff shortages affecting the residents' care.

The information received by the administrator alleged that due to a shortage of registered nursing staff, PSWs and dietary department staff multiple residents did not receive care and assistance required for health or well-being. The care and services alleged to have not been provided to multiple residents as required include or were provided late, that were the Activities of Daily Living (ADLs). Residents did not receive treatments and medications as ordered. Residents received double dose of medication. Assessments including residents after falls

and for pain were not done as scheduled. The alleged incidents occurred on multiple dates including identified dates in May, June, July and August 2019. The incidents allegedly included multiple residents on multiple shifts at times.

Review of Residents' Council minutes identified a concern raised by a resident related to staffing shortages for evening shift leaving no staff to watch the residents, who were still in the common area, while other staff were preparing residents for bed. Review of Family Council minute also identified a concern raised by a family member related to insufficient staffing during weekends. It was also mentioned that the same concern was raised by the staff during staff meetings.

The home's staffing plan did not meet the care and safety needs of residents related to medication administration.

A. The home's Medication Incident report involving resident #078 was reviewed and it was noted that on an identified date in May 2019, at identified time RN #177 administered specified medication to resident #078. Resident #078 was not prescribed that medication. Environmental, staffing or workflow problem was identified as the contributing factor. Workload was identified in the detail section. Registered staff #177 was contacted and they confirmed the accuracy of the information as documented in the specified report. The resident required additional monitoring as a result.

B. The home's Medication Incident involving resident #074 were reviewed and it was noted that on an identified date in June 2019, at identified time, RPN #161 administered specified medication to resident #074. RPN #161 did not sign the specified record at that time. At identified time, it was noted that RPN #180 administered specified medication to resident #074 and signed the specified record. RPN #161 informed RPN #180 that they administered the medication earlier but did not have a chance to sing the specified record and therefore the medication was administered twice.

The contributing factor was environmental, staffing, or workflow problem. Staffing deficiencies were identified in the detail section. Registered staff #161 reported that they worked one and a half floors that day due to a shortage of registered staff and, in addition, there was only one Personal Support Worker on one of the units. They were asked to help with providing personal care to the residents as well. The call bells were ringing. They started the medications and another

registered staff arrived to assist with the medication pass. They informed that staff that they administered the medication but had not signed for the medication as yet. That nurse continued with and completed the medication administration. Later, another nurse arrived and they did not communicate with registered staff #161. They noticed the one medication was not signed for and they administered the medication which was already administered to the resident but not signed for. The second Medication Incident report involving resident #074 was reviewed and it was noted that environmental, staffing or workflow problem was the number one contributing factor. Workload was identified in the detail section. Registered staff #180 confirmed the accuracy of the information as documented in the incident report. The resident required additional monitoring as a result.

C. The home's Medication Incident involving resident #076 was reviewed and it was noted that on an identified date in June 2019, at identified time, RPN #180 administered specified medication to resident #076 instead of another specified medication. Environmental, staffing or workflow problem was identified as the contributing factor. Staffing deficiencies was identified in the detail section. Registered staff #180 confirmed the accuracy of the information documented in the specified report. They reported the medication error occurred on a shift where registered staff were missing and, as a result, they were working on one and a half floors and they were probably rushing as a result. The resident required monitoring as well.

D. The home's Medication Incidents Analysis and Trends for an identified period from January to May 2019, was reviewed and it indicated that there was a noted increase in staff reporting related to workflow problems. Staff reported that errors were occurring with increased frequency when the registered staff were working not at their full complement and therefore required to work a floor and a half.

The home's specified Analysis and Trends for an identified period from June to August 2019, was reviewed and it indicated workload remained a contributing factor due to staff working a floor and a half frequently over the summer months.

DOC #107, confirmed nursing department staffing deployment when the registered staff was missing was for the registered staff work on one and a half home floors or more is a factor in the number of medication errors.

E. The Administrator reported that the home has been having issues related to

nursing department staffing shortages. They have made various strategies to address the issue. They provided documentation related to efforts to address the issue dating back to 2017. They also indicated that the home's management staff have come in and worked on the home areas to help with the nursing department staffing issues.

The home's nursing department staffing plan did not provide for a staffing mix of registered staff that was consistent with the residents' assessed care and safety needs related to medication administration.

2. The home's staffing plan on an identified date in September 2019, did not meet the residents' assessed care and safety needs related to specified assistance provided to the residents.

On an identified date during the inspection staff #109 confirmed that there was a float PSW missing during day shift in an identified home area.

On an identified date in September 2019, during residents' transfers observation during an identified period of time, there was one PSW available in the unit.

A. Resident #012 was transferred and provided toileting assistance by one PSW. In an interview with PSW #163 it was confirmed that the plan of care directed staff to provide two person assistance with toileting and transfers.

Review plan of care for resident #012 indicated that the resident required assistance by two staff for toileting and transferring. Physiotherapy assessment indicated that the resident needed two person specified assist for all surfaces.

Review of the home's "Resident handling: lifts, transfers and repositioning" policy indicated that that staff in the home adhered to designated lift and/or transfer status as identified on each resident's care plan and/or Kardex and/or resident lift.

During the inspection the Administrator indicated that the assistance with the transfers was to be provided by the registered staff if the second PSW staff was not available.

The home's nursing department staffing plan on an identified date in September 2019, did not provide for a staffing mix that was consistent with resident #021 assessed care and safety needs.

B. Resident #014 was transferred and provided toileting assistance by one PSW. In an interview with PSW #163 it was confirmed that the plan of care directed staff to provide two person assistance with toileting and transfers.

Review plan of care for resident #014 indicated that the resident required assistance by two staff and the use of specified assistive device for transfer and toileting. Physiotherapy assessment indicated that the resident needed two person assist using another specified device for all surfaces' specified activity.

Review of the home's "Resident handling: lifts, transfers and repositioning" policy indicated that staff in the home adhered to the designated lift and/or transfer status as documented on each resident's care plan and/or Kardex and/or resident's specified support.

During the inspection the Administrator indicated that the assistance with the transfer was to be provided by the registered staff if the second PSW staff was not available.

The home's nursing department staffing plan on an identified date in September 2019, did not provide for a staffing mix that was consistent with the resident #014s' assessed care and safety needs.

C. Resident #067 was transferred and provided toileting assistance by one PSW #163. In an interview with PSW #163 it was confirmed that the plan of care directed staff to provide two person assistance with toileting and transfers.

Review plan of care for resident #067 indicated that the resident required assistance by two staff for toileting and transferring. Physiotherapy assessment indicated that the resident needed two person assist for all surfaces.

Review of the home's "Resident handling: lifts, transfers and repositioning" policy indicated that staff in the home adhered to the designated lift and/or transfer status as documented on each resident's care plan and/or Kardex and/or resident's specified support.

During the inspection staff #109 confirmed that on an identified date in September 2019, there was a float PSW staff missed during day shift in an identified home area.

During the inspection the Administrator indicated that the assistance with the transfer was to be provided by the registered staff if the second PSW staff was not available.

The home's nursing department staffing plan on an identified date in September 2019, did not provide for a staffing mix of personal care staff that was consistent with the resident #067's assessed care and safety needs related to specified assistance.

3. The home's staffing plan, on identified dates in June and August 2019, did not meet the residents' assessed care and safety needs related to providing meals to the residents.

A. Review of Food and Fluid Intake forms indicated that on an identified date in June 2019, no breakfast was provided to resident #027 in an identified home area and it was coded as "SL" sleeping.

Review of the current written care plan identified that resident #027 was at nutrition risk and it was indicated to offer a specified amount of fluids at meals to the resident. Specified intervention were identified if the resident demonstrated an identified behaviour.

During the inspection, PSW #169 indicated that on a specified date in June 2019 resident #027 demonstrated the known behaviour.

Review of Daily Rooster Report and interview with staff #109 indicated that an identified home area of the home was missing one PSW float during specified shift.

The home's nursing department staffing plan on an identified date in June 2019, did not provide for a staffing mix of personal care staff that was consistent with the resident #027 in an identified home area assessed care and safety needs related to providing meals to the residents.

B. Review of Food and Fluid intake forms indicated that on an identified date in August 2019, no breakfast was provided to residents' #010, #028, #029, #030, #032 and #034 in an identified home area.

Review plan of care identified that the residents were all at nutritional risk.

Review of Daily Rooster Report, dated an identified date in August 2019, and interview with staff #109 indicated that an identified home area of the home was missing one PSW during specified shift.

During the inspection PSW #133 indicated that on an identified date in August 2019, an identified home area was missing two PSW staff on specified shift until identified period of time and the residents performed specified activity during breakfast due to staff shortage.

The home's nursing department staffing plan on an identified date in August 2019, did not provide for a staffing mix of personal care staff that was consistent with the residents' #010, #028, #029, #030, #032 and #034 in an identified home area assessed care and safety needs related to providing meals to the residents.

4. The home's staffing plan on identified dates in June, July and August 2019, did not meet the residents' assessed care and safety needs related to providing morning snacks.

A. Review Food and Fluid Intake forms indicated that on an identified date in June 2019, no morning nourishments were provided to 17 residents' #011, #012, #013, #014, #015, #016, #017, #018, #019, #020, #021, #022, #023, #024, #025, #026 and #027 in an identified home area.

Review plan of care identified that resident #011, #012, #013, #014, #015, #016, #017, #018, #020, #021, #022, #023, #024, #025, #026 and #027 were all at nutritional risk.

Review of Daily Rooster Report report dated an identified date in June 2019, and interview with staff #170 indicated that an identified home area of the home was missing one float PSW.

During the inspection PSW #169, indicated that on an identified date in June 2019, an identified home area was missing one PSW staff and there was no time to give morning nourishments to the residents at the scheduled nourishment time.

The home's nursing department staffing plan on an identified date in June 2019, did not provide for a staffing mix of personal care staff that was consistent with the

residents' #011, #012, #013, #014, #015, #016, #017, #018, #019, #020, #021, #022, #023, #024,# 025, #026 and #027 in an identified home area assessed care and safety needs related to providing morning nourishments to the residents.

B. Review specified forms indicated that on an identified date in July 2019, no morning nourishments were provided to residents' #035, #036, #037, #038, #039, #040, #041, #042, #043, #044, #045, #046, #047, #048 and #049 in an identified home area.

Review plan of care identified that resident #035, #036, #037, #038, #039, #040, #041, #042, #043, #046, #047, #048 and #049 were all at nutritional risk.

Review of specified report dated an identified date in July 2019, and interview with staff #170 indicated that an identified home area of the home was missing one PSW.

During the inspection PSW #170 indicated that on an identified date in July 2019, an identified home area was missing one PSW staff and there was no time to give morning nourishments at the scheduled nourishment time.

The home's nursing department staffing plan on an identified date in July 2019, did not provide for a staffing mix of personal care staff that was consistent with the residents' #035, #036, #037, #038, #039, #040, #041, #042, #043, #044, #045, #046, #047, #048 and #049 in an identified home area assessed care and safety needs related to providing morning nourishments to the residents.

C. Review specified forms indicated that on an identified date in August 2019, no morning nourishments were provided to residents' #010, #028, #029, #030, #031, #032, #033 and #034 in an identified home area.

Review plan of care identified that resident #010, #028, #029, #030, #031, #032, #033 and #034 were all at nutritional risk.

Review of specified report dated an identified date in August 2019, and interview with staff #170 indicated that an identified home area of the home was missing one PSW.

During the inspection PSW #133 indicated that on an identified date in August 2019, an identified home area was missing two PSW staff on specified shift until

an identified time and no morning nourishments were provided to the residents due to staff shortage.

The home's nursing department staffing plan on an identified date in August 2019, did not provide for a staffing mix of personal care staff that was consistent with the residents' #010, #028, #029, #030, #031, #032, #033 and #034 in an identified home area assessed care and safety needs related to providing morning nourishments to the residents.

5. The home's staffing plan on an identified date in September 2019, did not meet the residents' assessed care and safety needs related to bathing.

Observation of resident care and interviews with PSWs' #136, #137, #138, and #139 on an identified date in September 2019, identified that there was a staff shortage for specified shift in identified home areas. They indicated that they had two PSWs on each side, instead of the regular complement of three PSWs. They identified that baths and showers could not be provided to residents #050, #051, #052, and #053, who were scheduled to be bathed, as a result of being short staffed; the residents were given bed baths instead.

Observation of residents' care and interviews with PSW #140 and PSW #142 during the inspection on an identified date in September 2019, identified that there was a staffing shortage on the day shift in an identified home area. They indicated that they had two PSWs on each side and one PSW floating between the identified home areas, instead of the regular complement of three PSWs. Staff #140 identified that they did not complete the scheduled shower for resident #054, as they did not have enough time, and that the resident was provided a bed bath instead.

A. A review of resident #050's records, identified that they were to be bathed twice a week, and that they preferred to have baths.

B. A review of resident #051's records, identified that they were to be bathed twice a week. An interview with RPN #146 identified that the resident preferred to have showers.
C. A review of resident #052's records, identified that they were to be bathed twice a week, and that they preferred to have showers.

D. A review of resident #053's records, identified that they were to be bathed

twice a week, and that they preferred to have showers.

E. A review of resident #054's records, identified that they were to be bathed twice a week. An interview with RPN #146 identified that the resident preferred to have showers.

During an interview with DOC #107, they acknowledged that residents #050, #051 , #052, #053, and #054 were not given their preferred method of bathing and this preference was also not made up during the week. It was identified that it was an expectation that residents were bathed by the method of their choice, during their scheduled bath days.

The home's nursing department staffing plan on an identified date in September 2019, did not provide for a staffing mix of personal care staff that was consistent with the residents' #050, #051, #052, #053, and #054 assessed care and safety needs related to bathing preferences.

6. The home's staffing plan on an identified date in September 2019, did not meet the residents' assessed care and safety needs related to monitoring of residents' #063 and #064 during meals.

On an identified date in September 2019, during breakfast observation in an identified home area, there were two PSWs available in the home area and it was confirmed during the inspection by staff #109 that there was one float PSW missing during specified shift in an identified home area.

On an identified date in September 2019, during an identified period of time, it was observed that 16 residents had their breakfast in an identified dining room with no PSW staff present in the dining room. During this period of time, it was observed by Inspector #632 that two PSWs provided morning care to the rest of nine residents, who were still in their rooms. During breakfast observation on an identified date in September 2019, RPN #161 was standing beside their medication cart, located outside of the dining room, dispensing medications to the residents. Resident #064 was observed feeding breakfast to resident #063 with the spoon.

Staff #161 indicated that they did not see that resident #063 was fed by resident #064 and confirmed that it was not safe for resident #063.

A review of care plan for resident #063 indicated that resident #063 was at specified nutrition risk and had a specified risk related to an identified condition. The resident required specified assistance by one staff at identified period of the day.

The home's nursing department staffing plan, on an identified date in September 2019, did not provide for a staffing mix of personal care staff that was consistent with the residents' #063 assessed care and safety needs related to monitoring of residents' #063 and #064 during breakfast.

7. The home's staffing plan on an identified date in September 2019, did not meet the residents' assessed care and safety needs related to receiving supplementary staffing on specified shift.

Interview with PSW #150 and RPN #145 identified that they were both working on specified shift on an identified date in September 2019, in an identified home area. They indicated that there was shortage of staff, which resulted in no supplementary PSW staffing for resident #069 and resident #070.

Interview with Staffing Clerk #166 identified that the two supplementary PSW staff scheduled for the specified shift in an identified home area, were pulled from their assignment to other home areas due to staffing shortages.

DOC #101 and DOC #107 confirmed that resident #069 and resident #070 both had supplementary staffing. They acknowledged that resident #069 and resident #070 did not receive their supplementary staffing on specified shift, on an identified date in September 2019, as per their care plan.

The home's nursing department staffing plan on an identified date in September 2019, did not provide for a staffing mix of personal care staff that was consistent with the residents' #069 and #070 assessed care and safety needs related to receiving supplementary staffing on specified shift (748). [s. 31. (3)]

2. The licensee failed to ensure that the staffing plan included a back-up plan for personal care staffing that addressed situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, could not come to work.

A complaint log #016112-19 (IL-69390-HA) was submitted to the MOLTC outlining

staffing concerns in the home.

The licensee's staffing plan package "Staffing Plan - St. Joseph's Villa Long-Term Care" was reviewed. The documentation did not include a back-up plan for when the home was short-staffed. A separate document, not part of the staffing plan package, was provided, titled "Prioritizing a Floor and a Half", outlining the process for registered staff to follow, when registered staff were working short and needed to cover one half of another unit. A memo was also sent out to registered staff on an identified date in September 2018, outlining this.

There was no documentation outlining the back-up plan for PSW staff. This was confirmed by the Administrator and DOC #101.

Upon interview with registered staff #149, #150, #151, #158 and PSW's #147, #148, it was identified that there was no written back up plan that would direct PSW staff on how to address staffing situations when staff could not come to work. It was identified that staff were implementing their own strategies to deal with the staffing shortage, including but not limited to, not completing bathing or showers as scheduled, and not completing nourishment pass for residents. It was identified that in some instances, it was at the discretion of the PSWs whether or not bathing would be provided to the residents.

The licensee failed to ensure that the staffing plan included a back-up plan for personal care staffing that addressed situations, when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, could not come to work. [s. 31. (3) (d)]

Additional Required Actions:

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

(A3)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

The review of Medication Administration audits of medications, administered over one hour after they were scheduled to be administered/late, was conducted and included the following results:

On an identified date in August 2019, during specified shift, 69 residents in the home were noted to have received their medications over one hour past the scheduled time of administration/late.

On an identified date in August 2019, during specified shift, 74 residents in the home were noted to have received their medications over one hour past the scheduled time of administration/late.

On an identified date in August 2019, during specified shift, 121 residents in the home were noted to have received their medications over one hour past the scheduled time of administration/late.

ADOC #103 confirmed that Medication Incident reports were completed by the staff, when medications were administered over one hour after they were scheduled to be administered. They also confirmed that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

The Inspector and DOC #107 reviewed the home's Medication Incidents Analysis and Trends from an identified period in June to August 2019, and it was noted that there were only 30 Medication Incident reports documented for that period.

DOC #107 confirmed that in some instances, where one resident was administered the medication of another resident in error, Medication Incident report was not completed for the resident, who did not receive their medications as a result. They also, confirmed every medication incident involving a resident was not documented together with a record of the immediate actions taken to assess and maintain the resident's health, related to the late administration of medications, related to the late administration of medications.

The home’s Medication Incident records were reviewed. It was noted that on an identified date in June 2019, at an identified time, RPN #161 administered the wrong medications to resident #053. The resident, the resident’s SDM and the physician were informed of the incident. The physician gave orders that the resident’s vital signs were to be checked frequently and their health status was to be monitored. There was no Medication Incident report related to resident #075 found in the home’s Medication Incident records.

It was noted that on an identified date in May 2019, resident #078 was administered the wrong medication. The resident, the SDM and the physician were notified. The physician ordered the staff to monitor the resident’s vital signs. Environmental, staffing or workflow problem was noted to have been the number one factor and the detail section listed workload. There was no Medication Incident report related to the resident, who did not receive their medication as a result of the incident found in the home’s Medication Incident records.

2. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the the Medical Director.

The home's Medication Incident reports were reviewed, which noted that resident #021 was involved in a medication incident, which was not reported to the home's Medical Director. The incident, dated on an identified date in June 2019, noted that resident #076 was involved in a medication incident, which was not reported to the home's Medical Director; medication incident, dated on an identified date in July 2019, noted that resident #076 was involved in a medication incident, which was not reported to the home's Medical Director.

DOC #101 reported that the staff usually notified the attending and/or on-call Physicians of residents' medication incidents at the time of the incident. In some instances, the Medical Director was the also the resident's attending physician. However, if the Medical Director was not a resident's attending physician, they were not notified of a medication incident until they attended the Medication Management Committee meetings. At those meetings, all the Medication Incident reports for the quarter were reviewed. DOC #101 confirmed that the incidents noted above were not reported to the Medical Director when they occurred.

The home's Medication Management Committee Minutes were reviewed and it was noted that the Medical Director was not present.

The home did not ensure that every mediation incident, involving a resident, was reported to the Medical Director. [s. 135. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 004

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there was a written policy to promote zero tolerance of abuse and neglect of residents, and ensure shall ensure that the policy was complied with.

In accordance with O. Reg. 79/10, s. 5. Neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home's policy and procedure, Prevention of Abuse/Neglect Of A Resident, #POL/9, revised on an identified date in February 2019, was reviewed and it included: "Under Section 24 (1) of the LTC Act 2007, Reporting certain matters to the Director, 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 MOHLTC:" Abuse of a resident or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. Any concern or evidence regarding abuse/neglect must be immediately reported to the resident's substitute decision-maker (SDM)/first contact. Management will investigate all reports of alleged abuse or neglect and the most responsible person investigating the incident documents a detailed

report describing the situation including what, where, who, when and how.

On an identified date in August 2019, the Administrator confirmed they received the information alleging the neglect of multiple residents from May to August 2019, from an external source on an identified date in August 2019, and that they did not report the allegations to the MOLTC as per the home's policy and procedure.

The Administrator reported that, they received additional written information concerning the alleged neglect. The information provided by the home was reviewed and contained additional allegations which were not reported to the MOLTC.

The information received by the administrator alleged that due to a shortage of registered nursing staff, PSWs and dietary department staff multiple residents did not receive care and assistance required for health or well-being. The care and services alleged to have not been provided to multiple residents as required include or were provided late: assistance with activities of daily living such as continence care/toileting, baths, nourishments, getting dressed and out of bed. Residents who required the assistance of two staff were cared for by one staff on multiple occasions. Residents who required one-to-one care did not receive it. Residents did not receive treatments and medications as ordered. Residents received double dose of medication. Assessments including residents after falls and for pain were not done as scheduled. The alleged incidents occurred on identified dates in May, June, July and August 2019. The incidents allegedly included multiple residents on multiple shifts at times.

The Administrator was requested to provide documentation of the home's investigation into the alleged neglect of the residents and of the notification of the residents' SDMs. The Administrator confirmed that an investigation of the allegations was not initiated and that the residents' SDMs were not notified of the alleged neglect.

The home failed to ensure that it's abuse policy and procedure was complied with in relation to the immediate notification of the residents' SDMs and in relation to the immediate investigation of the allegations of neglect of residents received by the home on an identified date in August 2019. [s. 20. (1)]

Additional Required Actions:

(A2)(Appeal/Dir# DR# 131)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 005

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Complaint log #016112-19 ((IL-69698-HA) submitted to the MOLTC identified concerns that the home had a shortage of registered staff working on multiple shifts from May to August 2019.

A. The home's Medication Incident reports were reviewed, and it was noted that on an identified date in June 2019, RN #178 gave a medication to resident #021. Resident #021 self-administered the medication. The resident was not prescribed the medication. It was noted that the resident and the resident's Substitute Decision-Maker (SDM) were notified of the incident. Interventions were provided.

The administration of the resident's medication was also held.

DOC #107 confirmed the accuracy of the information noted above.

The licensee failed to ensure that no drug was used by resident #021 unless the drug had been prescribed for the resident.

B. The home's Medication Incident records were reviewed, and it was noted that on an identified date in June 2019, RPN #161 administered the wrong medications to resident #053. The medications of resident #075 were administered to the resident in error. The medications noted on the Incident Report did not include the administered medication. The resident, the resident's SDM and the physician were noted to have been informed of the incident. The physician gave orders that the resident's vital signs were to be checked frequently and their health status was to be monitored.

RPN #161 and DOC #107 confirmed the accuracy of the information noted above.

The licensee failed to ensure that no drug was administered to resident #053 unless the drug was prescribed for the resident.

C. The home's Medication Incident records were reviewed, and it was noted that on an identified date in May 2019, RN #177 administered medication to resident #078. Resident #078 was not prescribed that medication. The resident, the resident's SDM and the Medical Director were noted to have been informed of the incident. The physician gave orders to monitor the resident's some vital signs for the next 12 hours.

RN #177 and DOC #107 confirmed the accuracy of the information as noted above.

The licensee failed to ensure that medications were administered to resident #078 unless the drug was prescribed for the resident. [s. 131. (1)]

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

A. The home's Medication Incident records were reviewed, and it was noted that

on an identified date in June 2019, at identified time, RPN #161 administered medication to resident #074. RPN #161 did not sign the Medication Administration Record (MAR) at that time.

Minutes later, it was noted that RPN #180 administered medication again to resident #074 and signed the MAR record. RPN #161 informed RPN #180 that they administered the medication earlier but did not have a chance to sign the MAR and therefore the medication was administered twice. The resident, the resident's SDM and the physician were notified.

RPN #161 was interviewed and confirmed the information and noted above. RPN #180 and DOC #107 confirmed the accuracy as documented in the Medication Incident record.

On the same identified date, RPN #179 administered the wrong medication to resident #074. RPN #179 provided a specified intervention to resident #074. The resident, the resident's SDM and the physician were notified. The physician gave orders to hold the next scheduled dose of their medication and the staff were to monitor the resident's specified parameters.

RPN #179 and DOC #107 confirmed the accuracy of the information noted above.

The licensee failed to ensure that drugs were administered to resident #074 in accordance with the directions for use specified by the prescriber.

B. The home's medication incident records were reviewed and it was noted that on an identified date in June 2019, RPN #180 administered the wrong medication to resident #076. The resident, the resident's SDM and the physician were notified.

The Medication Incident record also indicated that on an identified date in July 2019, RPN #181 noted that resident #076 received the wrong medication. The medication was ordered on an identified date in June 2019, for one day only, as there was no another medication available. The medication remained in the resident's medication drawer since that time and it was half empty on an identified date in July 2019, when RPN #181 noticed the medication error. Registered staff checked the resident's parameters and they were within acceptable range. The resident, the resident's SDM and the physician were notified.

RPN #181 discarded the medication and monitored the resident's parameters.

RPN #181 and DOC #107 confirmed the accuracy of the information noted above.

The licensee failed to ensure that drugs were administered to resident #076 in accordance with the directions for use specified by the prescriber.

C. The home's Medication Incident records were reviewed. It was noted that on an identified date in July 2019, the Staff Educator, registered staff #174, discovered an unopened medication package containing resident #082's specified medications for that day, in the medication cart after administering resident's specified medications. The resident was assessed and there was no effects from missing the medication. It was noted the resident's SDM was notified however, there was no information/ blank, indicating the Medical Director/physician was notified.

The Mediation Audit Report, was reviewed and it was noted that resident #082's medications were not documented as being administered.

The licensee failed to ensure that drugs were administered to resident #082 in accordance with the directions for use specified by the prescriber.

D. It was noted that on an identified date in July 2019, the Staff Educator, registered staff #174, noticed resident #083's specified medication package in the medication drawer at identified time. The resident showed no effects of missing the medication pass. It was noted that the resident's SDM was notified however, there was no information/ blank space, indicating the Medical Director/physician was notified.

Another Medication Incident report noted that on an identified date in July 2019, the Staff Educator, registered staff #174, noticed at identified timer that resident #083 had not received their specified medication. The resident did not seem to have any negative effects as a result. Interventions were noted to be: educating the nursing team on medication delivery skills to prevent the events from happening.

The Mediation Audit Report, Missed Documentation, was reviewed and it was noted that on an identified date in July 2019, resident #083's, at identified time,

medications were not documented as being administered. There were no specified medications listed in the Mediation Audit Report, Missed Documentation, for resident #083.

The licensee failed to ensure that drugs were administered to resident #083 in accordance with the directions for use specified by the prescriber.

E. It was noted that on an identified date in July 2019, the Staff Educator, registered staff #174, found that resident #084's specified medications were not administered to the resident. The resident was assessed and there was no effect noted to the resident since the missed medications. The resident and their SDM were notified. There was no indication the Medical Director/physician was notified.

A separate medication of the same date at the same time indicated the resident's specified medications were not signed for. Interventions were noted to have been: counsel registered staff to check MAR/Treatment Administration Record (TAR) records an ensure they sing for the medications. Unknown if given. It was noted that the SDM was not notified. There was no documentation to indicate that the Medical Director/physician was notified.

The Mediation Audit Report, Missed Documentation, was reviewed and it was noted that on an identified date in July 2019, resident #084's specified medications were not documented as being administered.

DOC #107 confirmed the accuracy of the information as documented in the home's Medication Incident records.

The licensee failed to ensure that drugs were administered to resident #084 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

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

(A2)(Appeal/Dir# DR# 131)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 006

WN #7: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The home failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

1. Complaint log #016112-19 (IL-69390-HA) was submitted to the MOLTC related to staffing shortages affecting resident care, including bathing of residents.

A review of resident #051 and resident #054's records, identified that they did not have an identified method for bathing in their plan of care.

Interview with RPN #146 identified that resident #051 and resident #054 preferred to have identified methods of bathing and that this information was missing from their care plans.

Interview with DOC #107 identified that it was an expectation that resident's

choice or preference for bathing was in the care plan.

The home failed to ensure that resident #051 and resident #054's plan of care was based on the resident's needs and preferences.

2. Inspector #632 observed that on an identified date in September 2019, resident #014 was provided provided physical assistance with transfer by one PSW #163 in an identified home area. During interview PSW #163 confirmed that interventions for transfers and toileting assistance for resident #014 were to be provided by two staff and the use of specified device, as it was recoded in the Visual/Bedside Kardex Report printout.

Review plan of care for resident #014 indicated that the resident required an identified assistance by two staff and the use of specified device for transfers and toileting.

Physiotherapy assessment indicated that the resident needed two person assist using another specified device for all surfaces' transfer and nursing staff might go up any time.

During the inspection RAI Co-ordinator indicated that the resident's plan of care was to be updated by unit's registered staff, once transfer assessment was completed.

The licensee failed to ensure that the care set out in the plan of care for resident #014 was based on the transfer assessment of the resident (632). [s. 6. (2)]

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

A. Resident #059's plan of care included the use of a specified feeding device. The physician's orders included identified directions.

In an interview with RPN #151, they indicated that on an identified date in August 2019, they found the resident with the specified device still attached at an identified time, and that it was not disconnected as per the electronic MAR record. The staff member indicated this had happened multiple times.

RPN #157 reviewed the resident's MAR records with the LTCH Inspector and

confirmed through the interview that the specified device was to be disconnected at an identified time.

In an interview with RPN #143, they confirmed with the LTCH Inspector that PSW staff had removed the specified device in the morning, but that they had not gone in yet to complete other, related to the specified device, activities, even though this was scheduled to be done at an identified time as per the Physician's orders.

Resident #059 was not provided care as set out in the plan of care (586).

B. Interview with PSW #150 and RPN #145 identified that they were both working on the specified shift in September 2019, in an identified home area. They indicated that there was shortage of staff, which resulted in not providing an identified supplementary support for resident #069 and resident #070.

A review of residents #069's and #070's records, identified that the residents were cognitively impaired and exhibited an identified behavior. The residents' care plans indicated that an identified supplementary support was initiated on identified dates in August 2019, and it was to be in place during the specified shifts.

Interview with Staffing Clerk #166 identified that an identified supplementary support scheduled for the specified shift in an identified home area, were pulled from their identified assignment to other home areas due to staffing shortages.

DOC #101 and DOC #107 confirmed that resident #069 and resident #070 both had an identified supplementary support started. They acknowledged that resident #069 and resident #070 did not receive their identified supplementary support on the specified shift on an identified date in September 2019, as per their care plan (748).

C. Complaint log #016753-19 (IL-69698-HA) submitted to the MOLTC identified concerns related to short staffing in the home affecting resident's care. Review of specified report dated and interview with staff #109 indicated that an identified home area was missing one PSW during specified shift.

Review of Food and Fluid Intake documentation indicated that on an identified date in August 2019, resident #010, #028, #029, #030, #032 and #034, in an identified home area, were not provided morning care and breakfast.

Review plan of care identified that residents' #010, #028, #029, #030, #032 and #034 did not have any specified directions or interventions related to the morning care provided.

The licensee failed to ensure that the care set out in the plan of care for residents' #010, #028, #029, #030, #032 and #034 was provided to the residents as specified in the plan (632).

D. Review of the Food and Fluid Intake forms indicated that, on an identified date in June 2019, no breakfast and morning nourishment were provided to resident #027 in an identified home area.

Review written care plan identified that resident #027 was assessed at nutrition risk and it was indicated to offer specified nutrition intervention.

During the inspection PSW #169 indicated that on an identified date in June 2019, resident #027 exhibited specified behavior. RPN #178, who was working on an identified date in June 2019, was not available for the interview.

The licensee failed to ensure that specified nutrition intervention, as indicated in the plan of care, were provided to the resident as specified in their plan.

E. CIS report (CI 2975-000041-19), submitted to the MOLTC, was reviewed. It was noted that resident #001 had an identified incident and sustained an injury. The Head Injury Routine (HIR) was initiated. After an identified period of time the resident had a change in their health status.

Resident #001's health records were reviewed. The resident's change in their health status was specifically noted. The resident's plan of care indicated that the staff were to perform Cardiopulmonary Resuscitation (CPR) intervention in event of the resident experiencing change in their health status.

The review of the progress notes indicated that PSW #104 alerted RPN #105 that resident #001 exhibited identified signs and symptoms. RPN #105 then went to the staff room on the unit and notified Charge Nurse RN #100, who directed the registered staff to assess the resident's vital signs. The registered staff attempted to obtain the resident's vital signs but the attempt was not successful. Charge Nurse RN #100 and RPN #106 arrived to assist with the situation. They re-checked the resident and were unable to obtain any vital signs. Charge Nurse RN

#100 instructed the registered staff to alert ADOC #102 and the staff performed an identified action with the resident. ADOC #102 arrived and instructed Charge Nurse RN #100 to reassess the resident's vital signs but they were not found.

RPNs #105 and #106 as well as PSWs #104 and #173 were interviewed and reported information as contained in the progress notes. RPNs #105 and #106 confirmed resident #001's plan of care indicated staff were to perform CPR in the event of the resident experiencing identified symptoms and they verified that CPR was not performed. They reported CPR was not performed as staff did not witness the resident's identified change in their health status.

The DOC #107 confirmed resident #001 was not provided care as per their plan of care in relation to CPR.

This area of non-compliance was identified during CIS inspection #2019_558123_0011 (log #015523-19), which was conducted concurrently with this inspection (123).

F. The health record of resident #002 was reviewed and it was noted that the resident was to receive CPR if they experienced identified symptoms. Progress notes documentation indicated that the PSW informed the registered staff that the resident exhibited identified signs and symptoms. Registered staff went to assess the resident and noted the resident exhibited change in their health status. The registered staff went to the nursing station and confirmed resident was to receive CPR in the event of the resident experiencing change in their health status. The registered staff contacted the resident's substitute decision-maker (SDM) by telephone and informed them about the resident's change in their health status and suggested to send the resident to the hospital and the resident's SDM agreed. The registered staff identified the change in the resident's heath status and the SDM was notified.

DOC #107 reviewed the health record of resident #002 including the progress notes. DOC #107 and Inspector #123 spoke with RN #122. RN #122 indicated they were in the resident's room and confirmed they did not initiate CPR, since the identified symptoms were not witnessed.

DOC #107 confirmed the care set out in the plan of care was not provided to resident #002 as specified in the plan in relation to CPR.

This area of non-compliance was identified during CIS inspection #2019_558123_0011, which was conducted concurrently with this inspection (123).

G. The health record of resident #005, including the care plan and the progress notes, was reviewed and the plan of care indicated that the resident was to receive CPR in the event of the identified symptoms.

Progress notes documentation indicated that PSW staff noticed the resident change in their health status and alerted the registered staff. The registered staff identified change in the resident's health status. The registered staff attempted to assess the resident's identified signs but the resident exhibited change in their specified status. The registered staff from the adjacent home area contacted the resident's SDM, while the other registered staff continued to check for the resident's vital signs. It was noted that the resident's vital signs continued to change. It was noted there was a change in their health status and the physician was notified.

DOC #107 and Inspector #123 reviewed the health record of resident #005. DOC #107 confirmed the care set out in the plan of care was not provided to resident #005 as specified in the plan in relation to CPR.

This area of non-compliance was identified during CIS inspection #2019_558123_0011 (log #015523-19), which was conducted concurrently with this inspection (123).

Please note: this evidence further supports compliance order (CO) #001, that was issued on an identified date in July 2019, related to the same section, of the LTCHA 2007, s. 6(7), with a compliance due date on an identified date in October 2019.

This non-compliance occurred prior to the compliance due date (632). [s. 6. (7)]

3. The licensee failed to ensure that the provision of care set out in the plan of care related to bathing, was documented.

Complaint log #016112-19 (IL-69390-HA) was submitted to the MOLTC related to staffing shortages affecting resident care, including bathing of residents.

A. A review of the bath schedule for an identified home area, identified that residents #055, #056, #057, and #58, were scheduled to be bathed on an identified date in July 2019. A review of the residents' records identified that their bathing was not documented on the flow sheets sheets.

B. A review of the bath schedule for an identified home area, identified that residents #050, #051, #052, and #053, were scheduled to be bathed on an identified date in September 2019. A review of the resident's records identified that their bathing was not documented on the flow sheets sheets.

Interview with PSW #147 and #148, identified that the provision of care by PSWs were documented on the flow sheets in the PSW binders, and that they had not documented the bathing that they provided to residents #055, #056, #057, and #058, on an identified date in July 2019.

Observation of resident care and interviews with staff #136, #137, #138, and #139 on an identified date in September 2019, identified that there was a shortage of staff for the specified shift in an identified home area. They identified that baths and showers could not be provided to residents #051, #52, #053, and #054, as a result of being short staffed; and that the residents were given specified baths instead.

Interview with RPN #146 during the inspection confirmed that the specified baths that were provided to the residents on an identified date in September 2019, were not documented on the flow sheets.

Interview with the DOC #101 and DOC #107 identified that it was an expectation that the provision of bathing was documented.

The home failed to ensure that the provision of bathing for residents #050, #051, #052, #053, #055, #056, #057, and #058, was documented. [s. 6. (9) 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 and ensuring that the plan of care is based on an assessment of the resident and the resident's needs and preferences and the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #8: 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 failed to ensure that every plan, policy, protocol, procedure, strategy and system was complied with.

1. In accordance with Ontario Regulation 79/10, s. 52, the licensee was required to have an organized specified program and to ensure pain assessment methods were developed for those experiencing pain who could not communicate this pain, as well as the monitoring of residents' responses to the pain management strategies.

The licensee's "Assessment Requirements by Registered Staff" indicated that pain assessments using the Pain Assessment in Advanced Dementia (PAINAD) or Pain Tool in Point Click Care (PCC) were required to be completed, when a resident was on specified medications or at any time identified interventions were not effective. This was confirmed by DOC #101 and RPN #106.

A. Resident #060 had a physician's order for pain assessment. Upon review of

the resident's health record, it was identified that they did not receive the pain assessment on identified dates in May 2019. DOC #101 confirmed this was not completed and also confirmed that it should have been completed.

B. Resident #061 had a physician's order for a specified medication and their documented plan of care indicated that they experienced pain and directed staff to assess for pain. Upon review of the resident's health record, it was identified that they did not receive a pain assessment on an identified date in May 2019. DOC #101 confirmed this was not completed and also confirmed that it should have been completed.

The licensee's pain assessment protocol was not complied with (586).

2. In accordance with Ontario Regulation 79/10, s. 68, the licensee was required to have an organized program of nutrition care and dietary services and hydration and to ensure policies and procedures were developed, in consultation with a registered dietitian, and implemented, as well as the implementation of interventions to mitigate and manage and risk.

The licensee's "Gastrostomy & Nasogastric Tube Feeding" policy directed RNs and RPNs on the specified feeding devices care for residents.

Resident #059's documented plan of care included the use of a specified feeding device. The physician's orders included directions on the use and care for the device.

In an interview with RPN #143, they indicated that they relied on the full-time PSW staff to disconnect resident #059's feeding device at an identified time, while providing care. Then they would go in later during their medications pass rounds to complete the rest, and that this was done at an identified frequency. RD #152 and DOC #107 confirmed that it was the responsibility of registered staff only to provide the specified feeding devices care, not the PSWs.

The licensee's "Gastrostomy & Nasogastric Tube Feeding" policy was not complied with (586).

3. In accordance with LTCHA 2007, s. 8. (1) (b), the licensee was required a long-term care home to ensure that there was an organized program of nursing services for the home to meet the assessed needs of the resident.

The home's Code Blue policy and procedure were reviewed and it included, where appropriate or based on the advanced plan of care of an individual resident, certified staff should initiate CPR at the Basic Cardiac Life Support (BCLS) level until emergency medical service personnel arrived to initiate specified support. It also included that the registered staff must maintain certification at an identified level. Education was provided annually by the home's external service provider and was recommended at least every two years.

The home's staff Administrator reported that the home's external specified service provider offered CPR education to the staff. The staff may also choose to obtain CPR certification from outside agencies. The staff were required to obtain BCLS certification every two years. If the staff completed the course offered by specified service provider, they received the certification electronically and they presented the certification to the home and it was recorded in their educational file. The Administrator provided the CPR certification records of registered staff #100, registered staff #106 and registered staff #105. The Administrator and the Staff Educator confirmed registered staff #100, #105 and #106 completed their CPR certification course through the home’s external service provider. A copy of registered staff #175's specified certification was also reviewed. The home was asked to provide the record of the CPR certification of registered staff #122 and it was not provided. HR Manager #176 reported they had no record of registered staff #122's CPR certification. HR Manager #176 reported that the renewal date of the CPR certificates of registered staff #100, #105 and #105, reflected the event date and or the date of their CPR certification.

The Inspector requested course information related to the CPR certification offered by the home to the staff. The Staff Educator provided a copy of their specified certificate and the course description information. They reported the certificate was issued after the completion of the course offered by the home to the staff, which was provided by the home’s external service provider. The course information indicated that specified service provider's course was designated for people who don’t have medical training but who wanted to learn how to help someone having identified symptoms. The staff educator confirmed that the certificates of registered staff #100, #105, #106 and #175 were CPR certificates at the specified service provider's level. The course was for people, who did not have a health care background and it was not equivalent to the BCLS course level, which was for health care workers and the certification required annual renewal. They also confirmed that the home did not follow it’s Code Blue

CPR policy and procedure related to staff CPR requirements as noted above.

This area of non-compliance was identified during CIS inspection #2019_558123_0011, which was conducted concurrently with the complaint inspection (123).

4. In accordance with O. Reg. 79/10, s. 114 (2), the licensee should ensure that written policies and protocols were developed for the medication management system to ensure the acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home's Medication Administration Rounds policy and procedure was reviewed and it included that if a resident refused an identified medication to dispose the medication. It stated to use the appropriate charting on the electronic MAR record and to document why the dose was not administered in the progress notes of the resident's health record. These were confirmed with ADOC #103 and DOC #107.

ADOC #103 was reported that it is the home's expectation that when a resident was not administered their medication the reason was to be documented in the resident's MAR record by using of the provided number codes.

A. The July and August, 2019's MARs records of resident #079 were reviewed:

i. The resident was ordered to receive specified medications. There was a blank space/no documentation on an identified dates in July 2019.

ii. The resident was to receive specified medication at identified frequency on the following identified dates in July and August 2019, however, there was no documentation.

iii. The resident was to receive specified medication at identified frequency and there was no documentation on an identified date in August 2019.

B. The July 2019's MAR record of resident #080 was reviewed and they were to receive specified medications at identified frequency and there was no documentation on identified dates in July 2019.

C. The August 2019's MAR record of resident #081 was reviewed and they were

to receive specified medications at identified frequency for an identified period of time and there was no documentation for identified dates in August 2019.

The home's Medication Administration Rounds policy was not complied with. [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 and ensuring that "Assessment Requirements by Registered Staff" protocol related to pain assessment, "Gastrostomy & Nasogastric Tube Feeding" policy, Code Blue policy and Medication Administration Rounds policy were complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Complaint log #016112-19 (IL-69390-HA) was submitted to the MOLTC related to staffing shortages affecting resident care, including bathing of residents.

Observation of resident care and interviews with PSWs' #136, #137, #138, and #139 on an identified date in September 2019, identified that there was a shortage of staff for the day shift in identified home areas. They indicated that they had two PSWs on each side, instead of the regular complement of three PSWs. They identified that the preferred methods of bathing for residents #050, #051, #052, and #053, were not provided to them, as a result of being short staffed and that the residents were given specified baths instead.

Observation of residents' care and interviews with PSW #140 and PSW #142 during the inspection identified that there was a shortage of staff for the day shift in an identified home area. They indicated that they had two PSWs on each side and one PSW floating between identified home areas, instead of the regular complement of three PSWs. Staff #140 identified that they did not complete the preferred method of bathing for resident #054, as they did not have enough time, and that the resident was provided specified bath instead.

A review of resident #050's, #051's, #052's and #053's records, identified that they preferred to specified method of bathing. An interview with RPN #146 identified that the resident preferred to have specified method of bathing.

During an Interview with DOC #107, they acknowledged that residents #050, #051, #052, #053, and #054 were not given their preferred method of bathing, and this preference was also not made up during the week. It was identified that it was an expectation that residents were bathed by the method of their choice, during their scheduled bath days.

The licensee failed to ensure that residents' #050, #051, #052, #053, and #054, were bathed, by the method of their choice, related to staffing shortages. [s. 33. (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 and ensuring that residents are bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #10: 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:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining service that included, at minimum, the following elements: (4) monitoring of all residents during meals.

Complaint log #016112-19 (IL-69390-HA) submitted to the MOLTC identified concerns related to staffing shortage in the home affecting residents' care, was reviewed.

On an identified date in September 2019, the observation of meal time in an identified home area was conducted. There were two PSWs available in the home area and it was confirmed during the inspection by staff #109 that there was one float PSW missing during specified shift in an identified home area.

On an identified date in September 2019, there was observed that 16 residents had their meal in an identified dining room with no PSW staff present in the dining room. It was observed by Inspector #632 that two PSWs provided morning care to the rest of nine residents. During the meal observation, RPN #161 was standing beside their medication cart, located outside of the dining room, dispensing medications to the residents. Resident #064 was observed feeding resident #063, who was cognitively impaired and had some identified conditions.

Staff #161 indicated that they did not see that resident #063 was fed by resident #064 and confirmed that it was not safe for resident #063.

A review of care plan for resident #063 indicated that the resident was at nutrition risk and was at risk having specified condition. The resident required identified assistance by one staff at identified period of time.

The licensee failed to ensure that on an identified date in September 2019, an identified dining service included monitoring of resident #063 during meal time. [s. 73. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the home has a dining service that includes, at minimum, the following elements: (4) monitoring of all residents during meals, to be implemented voluntarily.

Issued on this 17th day of June, 2020 (A3)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by STACEY GUTHRIE (750) - (A3)
Inspection No. / No de l'inspection :	2019_560632_0020 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	016112-19, 016753-19 (A3)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 17, 2020(A3)
Licensee / Titulaire de permis :	St. Joseph's Health System 50 Charlton Avenue East, Room M146, HAMILTON, ON, L8N-4A6
LTC Home / Foyer de SLD :	St. Joseph's Villa, Dundas 56 Governor's Road, DUNDAS, ON, L9H-5G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mieke Ewen

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

To St. Joseph's Health System, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

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

Specifically, the licensee must:

1. Ensure staff working in Oak Grove home area use safe transferring techniques, when assisting residents' #012, #014 and #067 and all other residents.

2. Ensure all direct care staff working in Oak Grove home area receive retraining regarding safe transferring techniques when assisting residents' #012, #013 and #067 and all other residents.

3. Establish an auditing process to ensure that staff working in Oak Grove home area, using transferring devices or techniques to assist residents #012, #013 and #067, are using safe techniques appropriate to the needs of the resident.

4. Ensure documentation be retained of staff retraining and staff audit results.

Grounds / Motifs :

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

Complaint log #016112-19 (IL-69390-HA), submitted to the Ministry of Long-Term

Care (MOLTC), identified concerns related to staffing shortage in the home affecting residents' care, was reviewed.

On an identified date in September 2019, LTC Home Inspector #632 observed care provided to residents in an identified home area. During the observation, one PSW was available on the home area when three residents requested to go to the bathroom. The following observations were made related to safe transferring:

A. Resident #012 was transferred and provided toileting assistance by one PSW. In an interview with PSW #163 it was confirmed that the plan of care directed staff to provide two person assistance with toileting and transfers.

Review plan of care for resident #012 indicated that the resident required assistance by two staff for toileting and transferring. Physiotherapy assessment indicated that the resident needed two person specified assist for all surfaces.

Review of the home's "Resident handling: lifts, transfers and repositioning" policy indicated that that staff in the home adhered to designated lift and/or transfer status as identified on each resident's care plan and/or Kardex and/or resident lift.

During the inspection the Administrator indicated that the assistance with the transfers was to be provided by the registered staff if the second PSW staff was not available.

The licensee failed to ensure that staff used safe transferring and positioning techniques techniques, when assisting resident #012.

B. Resident #014 was transferred and provided toileting assistance by one PSW. In an interview with PSW #163 it was confirmed that the plan of care directed staff to provide two person assistance with toileting and transfers.

Review plan of care for resident #014 indicated that the resident required assistance by two staff and the use of specified assistive device for transfer and toileting. Physiotherapy assessment indicated that the resident needed two person assist using another specified device for all surfaces' specified activity.

Review of the home's "Resident handling: lifts, transfers and repositioning" policy

indicated that staff in the home adhered to the designated lift and/or transfer status as documented on each resident's care plan and/or Kardex and/or resident's specified support.

During the inspection the Administrator indicated that the assistance with the transfer was to be provided by the registered staff if the second PSW staff was not available.

The licensee failed to ensure that staff used safe transferring and positioning techniques techniques, when assisting resident #014.

C. Resident #067 was transferred and provided toileting assistance by one PSW #163. In an interview with PSW #163 it was confirmed that the plan of care directed staff to provide two person assistance with toileting and transfers.

Review plan of care for resident #067 indicated that the resident required assistance by two staff for toileting and transferring. Physiotherapy assessment indicated that the resident needed two person assist for all surfaces.

Review of the home's "Resident handling: lifts, transfers and repositioning" policy indicated that staff in the home adhered to the designated lift and/or transfer status as documented on each resident's care plan and/or Kardex and/or resident's specified support.

During the inspection staff #109 confirmed that on an identified date in September 2019, there was a float PSW staff missed during day shift in an identified home area.

During the inspection the Administrator indicated that the assistance with the transfer was to be provided by the registered staff if the second PSW staff was not available.

The licensee failed to ensure that staff used safe transferring and positioning techniques techniques, when assisting resident #067.

This order is made up on the application of the factors of severity (2), scope (3), and compliance history (3). This is in respect to the severity of minimal harm or minimal risk that identified residents experienced, the scope of this being widespread incident. The home had a level 3 history as they had previous noncompliance to the

same subsection of the LTCHA that included:
- Voluntary Plan of Correction (VPC) issued August 2019 (2019_555506_0005).
(632)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 20, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 71. (3) a of the LTCHA.

Specifically the licensee must:

1. Ensure that residents' #010, #027, #028, #029, #030, #031, #032, #033 and #034 and all other residents are offered breakfast daily.

2. Ensure that residents' #010, #011, #012, #013, #014, #015, #016, #017, #018, #019, #020, #021, #022, #023, #024, #025, #026, #027, #028, #029, #030, #031, #032, #033, #034, #035, #036, #037, #038, #039, #040, #041, #042, #043, #044, #045, #046, #047, #048, #049 and all other residents are offered a minimum of a between-meal beverage in the morning.

3. Develop and implement an auditing system to identify if residents are offered breakfast daily and a minimum of a between-meal beverage in the morning.

4. Maintaining the documentation of the auditing system.

Grounds / Motifs :

1. The licensee failed to ensure that each resident was offered (a) a minimum of

three meals daily.

A. Review of Food and Fluid Intake forms indicated that on an identified date in June 2019, no breakfast was provided to resident #027 in an identified home area and it was coded as "SL" sleeping.

Review of the current written care plan identified that resident #027 was at nutrition risk and it was indicated to offer a specified amount of fluids at meals to the resident. Specified intervention were identified if the resident demonstrated an identified behaviour.

During the inspection, PSW #169 indicated that on a specified date in June 2019 resident #027 demonstrated the known behaviour.

The licensee failed to ensure that on the identified date in June 2019 resident #027 was offered (a) breakfast.

B. Complaint log #016753-19 (IL-69698-HA), submitted to the MOLTC, identified concerns related to staffing shortage in the home affecting resident's care.

Review of Food and Fluid intake forms indicated that on an identified date in August 2019, no breakfast was provided to residents' #010, #028, #029, #030, #032 and #034 in an identified home area.

Review plan of care identified that the residents were all at nutritional risk.

During the inspection, PSW #133 indicated that on an identified date, the home area was missing two PSWs for a period of time during the shift and the residents remained in bed and were not provided assistance to get to the dining room due to staffing shortage.

The licensee failed to ensure that on an identified date in August 2019, residents' #010, #028, #029, #030, #032 and #034 in an identified home area were offered (a) a minimum of breakfast.

This order is made up on the application of the factors of severity (2), scope (2), and compliance history (3). This is in respect to the severity of minimal harm or minimal

risk that identified residents experienced, the scope of this being pattern incident. The home had a level 3 history as they had previous noncompliance to the same subsection of the LTCHA that included:
- Written Notification (WN) issued June 11, 2019 (2019_570528_0012). (632)

2. The licensee failed to ensure that each resident was offered a minimum of (b) a between-meal beverage in the morning.

Complaint log #016112-19 (IL-69390-HA) submitted to the MOLTC, identified concerns related to staffing shortage in the home affecting residents' care, was reviewed.

A. Review Food and Fluid Intake forms indicated that on an identified date in June 2019, no nourishments were provided to 17 residents (including residents' #011, #012, #013, #014, #015, #016, #017, #018, #019, #020, #021, #022, #023, #024, #025, #026 and #027) at specified period of the day in an identified home area.

Review plan of care identified that the residents were all at nutritional risk.

During the inspection, PSW #169, indicated that on an identified date, an identified home area was missing one PSW staff and there was no time to give nourishments to the residents at the scheduled nourishment time.

The licensee failed to ensure that on an identified date in June 2019, residents' #011, #012, #013, #014, #015, #016, #017, #018, #019, #020, #021, #022, #023, #024, #025, #026 and #027 in an identified home area were offered a minimum of (b) a between-meal beverage at specified period of the day.

B. Review of Food and Fluid Intake forms indicated that on an identified date in July 2019, no nourishments were provided to residents' #035, #036, #037, #038, #039, #040, #041, #042, #043, #044, #045, #046, #047, #048 and #049 in an identified home area at specified period of the day.

Review plan of care identified that the residents were all at specified nutritional risk.

During the inspection PSW #170 indicated that on an identified date, an identified home area was missing one PSW staff and there was no time to give nourishments to the residents at the scheduled nourishment time.

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 failed to ensure that on an identified date in July 2019, residents' #035, #036, #037, #038, #039, #040, #041, #042, #043, #044, #045, #046, #047, #048 and #049 in an identified home area were offered a minimum of (b) a between-meal beverage at specified period of the day.

C. Review of Food and Fluid intake forms indicated that on an identified date in August 2019, no nourishments at specified period of the day were provided to residents' #010, #028, #029, #030, #031, #032, #033 and #034 in an identified home area.

Review of the plan of care identified that resident #010, #028, #029, #030, #031, #032, #033 and #034 were all assessed to be at nutritional risk.

During the inspection PSW #133 indicated that on an identified date, an identified home area was missing two PSWs staff and no nourishments were provided to the residents due to the staffing shortage.

The licensee failed to ensure that on an identified date in August 2019, residents' #010, #028, #029, #030, #031, #032, #033 and #034 in an identified home area were offered a minimum of (b) a between-meal beverage at the specified period of the day.

This order is made up on the application of the factors of severity (2), scope (3), and compliance history (3). This is in respect to the severity of minimal harm or minimal risk that identified residents experienced, the scope of this being widespread incident. The home had a level 3 history as they had previous noncompliance to the same subsection of the LTCHA that included:
- VPC issued August 2019 (2019_555506_0005);
- WN issued June 11, 2019 (2019_570528_0012). (632)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 20, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/19, s. 31. (3) of the LTCHA.

Specifically, the licensee must:

1. Provide for a staffing mix that is consistent with resident' assessed care and safety needs and that meets the requirements set out in the Act and Regulation.

2. Ensure adequate staff mix of registered nursing staff to properly administer medications.

3. Ensure adequate staff mix of personal care staff to ensure that the residents are bathed at a minimum of two days a week by the method of their choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

4. Ensure adequate staff mix of personal care staff to ensure that all residents are offered breakfast daily.

5. Ensure adequate staff mix of personal care staff to ensure that all resident are offered a minimum of a between-meal beverage in the morning.

6. Have a back-up plan for personal care staffing that addresses situations when staff, including the staff, who must provide the nursing coverage, can not come to work.

Grounds / Motifs :

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

Complaint log #016112-19 (IL-69390-HA), received by the MOLTC, was reviewed. It alleged that from May to August 2019, there was ongoing nursing department staffing shortages in the home affecting resident care.

St. Joseph's Villa is a Long-Term Care Home (LTCH) with a licensed capacity of 425

beds. The licensee used a "Nursing Department Staffing – updated May 7, 2019", which had a staffing mix over a 24 hours (hrs) period.

During the inspection, the DOC #107 provided to Inspector #632 Staffing Plan-St. Joseph's Villa Long-Term Care, which contained staff planning (shift start/end, days per week, etc.) by department. In the documentation provided by the Administrator it was indicated that in November 2017, additional PSWs' hours to 2 North and 4 South were added. The goal of these hours is to ensure that the units have 3 PSWs on the floors, during the busiest time each morning. "We are pleased to announce that we will be adding additional PSWs' hours to 2 South and 3 South... These hours are temporary at present, but we will reassess this in the New Year, and determine a fulsome plan".

During the inspection, the Administrator provided to Inspectors' #123 and #632 CUPE 1404 Workload Review forms (for an identified period from May to August 2019), submitted by the home's employees to their union. Review of the forms identified that out of the total of 43 submitted concerns, there were 21 concerns related to personal care staffing shortages in the home that affected the residents' care. Also, there were six concerns related to registered staff shortages affecting the residents' care.

The information received by the administrator alleged that due to a shortage of registered nursing staff, PSWs and dietary department staff multiple residents did not receive care and assistance required for health or well-being. The care and services alleged to have not been provided to multiple residents as required include or were provided late, that were the Activities of Daily Living (ADLs). Residents did not receive treatments and medications as ordered. Residents received double dose of medication. Assessments including residents after falls and for pain were not done as scheduled. The alleged incidents occurred on multiple dates including identified dates in May, June, July and August 2019. The incidents allegedly included multiple residents on multiple shifts at times.

Review of Residents' Council minutes identified a concern raised by a resident related to staffing shortages for evening shift leaving no staff to watch the residents, who were still in the common area, while other staff were preparing residents for bed. Review of Family Council minute also identified a concern raised by a family member related to insufficient staffing during weekends. It was also mentioned that the same

concern was raised by the staff during staff meetings.

1. The home's staffing plan did not meet the care and safety needs of residents related to medication administration.

A. The home's Medication Incident report involving resident #078 was reviewed and it was noted that on an identified date in May 2019, at identified time RN #177 administered specified medication to resident #078. Resident #078 was not prescribed that medication. Environmental, staffing or workflow problem was identified as the contributing factor. Workload was identified in the detail section. Registered staff #177 was contacted and they confirmed the accuracy of the information as documented in the specified report. The resident required additional monitoring as a result.

B. The home's Medication Incident involving resident #074 were reviewed and it was noted that on an identified date in June 2019, at identified time, RPN #161 administered specified medication to resident #074. RPN #161 did not sign the specified record at that time. At identified time, it was noted that RPN #180 administered specified medication to resident #074 and signed the specified record. RPN #161 informed RPN #180 that they administered the medication earlier but did not have a chance to sing the specified record and therefore the medication was administered twice.

The contributing factor was environmental, staffing, or workflow problem. Staffing deficiencies were identified in the detail section. Registered staff #161 reported that they worked one and a half floors that day due to a shortage of registered staff and, in addition, there was only one Personal Support Worker on one of the units. They were asked to help with providing personal care to the residents as well. The call bells were ringing. They started the medications and another registered staff arrived to assist with the medication pass. They informed that staff that they administered the medication but had not signed for the medication as yet. That nurse continued with and completed the medication administration. Later, another nurse arrived and they did not communicate with registered staff #161. They noticed the one medication was not signed for and they administered the medication which was already administered to the resident but not signed for. The second Medication Incident report involving resident #074 was reviewed and it was noted that environmental, staffing or workflow problem was the number one contributing factor.

Workload was identified in the detail section. Registered staff #180 confirmed the accuracy of the information as documented in the incident report. The resident required additional monitoring as a result.

C. The home's Medication Incident involving resident #076 was reviewed and it was noted that on an identified date in June 2019, at identified time, RPN #180 administered specified medication to resident #076 instead of another specified medication. Environmental, staffing or workflow problem was identified as the contributing factor. Staffing deficiencies was identified in the detail section. Registered staff #180 confirmed the accuracy of the information documented in the specified report. They reported the medication error occurred on a shift where registered staff were missing and, as a result, they were working on one and a half floors and they were probably rushing as a result. The resident required monitoring as well.

D. The home's Medication Incidents Analysis and Trends for an identified period from January to May 2019, was reviewed and it indicated that there was a noted increase in staff reporting related to workflow problems. Staff reported that errors were occurring with increased frequency when the registered staff were working not at their full complement and therefore required to work a floor and a half.

The home's specified Analysis and Trends for an identified period from June to August 2019, was reviewed and it indicated workload remained a contributing factor due to staff working a floor and a half frequently over the summer months.

DOC #107, confirmed nursing department staffing deployment when the registered staff was missing was for the registered staff work on one and a half home floors or more is a factor in the number of medication errors.

E. The Administrator reported that the home has been having issues related to nursing department staffing shortages. They have made various strategies to address the issue. They provided documentation related to efforts to address the issue dating back to 2017. They also indicated that the home's management staff have come in and worked on the home areas to help with the nursing department staffing issues.

The home's nursing department staffing plan did not provide for a staffing mix of

registered staff that was consistent with the residents' assessed care and safety needs related to medication administration.

2. The home's staffing plan on an identified date in September 2019, did not meet the residents' assessed care and safety needs related to specified assistance provided to the residents.

On an identified date during the inspection staff #109 confirmed that there was a float PSW missing during day shift in an identified home area.

On an identified date in September 2019, during residents' transfers observation during an identified period of time, there was one PSW available in the unit.

A. Resident #012 was transferred and provided toileting assistance by one PSW. In an interview with PSW #163 it was confirmed that the plan of care directed staff to provide two person assistance with toileting and transfers.

Review plan of care for resident #012 indicated that the resident required assistance by two staff for toileting and transferring. Physiotherapy assessment indicated that the resident needed two person specified assist for all surfaces.

Review of the home's "Resident handling: lifts, transfers and repositioning" policy indicated that that staff in the home adhered to designated lift and/or transfer status as identified on each resident's care plan and/or Kardex and/or resident lift.

During the inspection the Administrator indicated that the assistance with the transfers was to be provided by the registered staff if the second PSW staff was not available.

The home's nursing department staffing plan on an identified date in September 2019, did not provide for a staffing mix that was consistent with resident #021 assessed care and safety needs.

B. Resident #014 was transferred and provided toileting assistance by one PSW. In an interview with PSW #163 it was confirmed that the plan of care directed staff to provide two person assistance with toileting and transfers.

Review plan of care for resident #014 indicated that the resident required assistance by two staff and the use of specified assistive device for transfer and toileting. Physiotherapy assessment indicated that the resident needed two person assist using another specified device for all surfaces' specified activity.

Review of the home's "Resident handling: lifts, transfers and repositioning" policy indicated that staff in the home adhered to the designated lift and/or transfer status as documented on each resident's care plan and/or Kardex and/or resident's specified support.

During the inspection the Administrator indicated that the assistance with the transfer was to be provided by the registered staff if the second PSW staff was not available.

The home's nursing department staffing plan on an identified date in September 2019, did not provide for a staffing mix that was consistent with the resident #014s' assessed care and safety needs.

C. Resident #067 was transferred and provided toileting assistance by one PSW #163. In an interview with PSW #163 it was confirmed that the plan of care directed staff to provide two person assistance with toileting and transfers.

Review plan of care for resident #067 indicated that the resident required assistance by two staff for toileting and transferring. Physiotherapy assessment indicated that the resident needed two person assist for all surfaces.

Review of the home's "Resident handling: lifts, transfers and repositioning" policy indicated that staff in the home adhered to the designated lift and/or transfer status as documented on each resident's care plan and/or Kardex and/or resident's specified support.

During the inspection staff #109 confirmed that on an identified date in September 2019, there was a float PSW staff missed during day shift in an identified home area.

During the inspection the Administrator indicated that the assistance with the transfer was to be provided by the registered staff if the second PSW staff was not available.

The home's nursing department staffing plan on an identified date in September 2019, did not provide for a staffing mix of personal care staff that was consistent with the resident #067's assessed care and safety needs related to specified assistance.

3. The home's staffing plan, on identified dates in June and August 2019, did not meet the residents' assessed care and safety needs related to providing meals to the residents.

A. Review of Food and Fluid Intake forms indicated that on an identified date in June 2019, no breakfast was provided to resident #027 in an identified home area and it was coded as "SL" sleeping.

Review of the current written care plan identified that resident #027 was at nutrition risk and it was indicated to offer a specified amount of fluids at meals to the resident. Specified intervention were identified if the resident demonstrated an identified behaviour.

During the inspection, PSW #169 indicated that on a specified date in June 2019 resident #027 demonstrated the known behaviour.

Review of Daily Rooster Report and interview with staff #109 indicated that an identified home area of the home was missing one PSW float during specified shift.

The home's nursing department staffing plan on an identified date in June 2019, did not provide for a staffing mix of personal care staff that was consistent with the resident #027 in an identified home area assessed care and safety needs related to providing meals to the residents.

B. Review of Food and Fluid intake forms indicated that on an identified date in August 2019, no breakfast was provided to residents' #010, #028, #029, #030, #032 and #034 in an identified home area.

Review plan of care identified that the residents were all at nutritional risk.

Review of Daily Rooster Report, dated an identified date in August 2019, and interview with staff #109 indicated that an identified home area of the home was missing one PSW during specified shift.

During the inspection PSW #133 indicated that on an identified date in August 2019, an identified home area was missing two PSW staff on specified shift until identified period of time and the residents performed specified activity during breakfast due to staff shortage.

The home's nursing department staffing plan on an identified date in August 2019, did not provide for a staffing mix of personal care staff that was consistent with the residents' #010, #028, #029, #030, #032 and #034 in an identified home area assessed care and safety needs related to providing meals to the residents.

4. The home's staffing plan on identified dates in June, July and August 2019, did not meet the residents' assessed care and safety needs related to providing morning snacks.

A. Review Food and Fluid Intake forms indicated that on an identified date in June 2019, no morning nourishments were provided to 17 residents' #011, #012, #013, #014, #015, #016, #017, #018, #019, #020, #021, #022, #023, #024, #025, #026 and #027 in an identified home area.

Review plan of care identified that resident #011, #012, #013, #014, #015, #016, #017, #018, #020, #021, #022, #023, #024, #025, #026 and #027 were all at nutritional risk.

Review of Daily Rooster Report report dated an identified date in June 2019, and interview with staff #170 indicated that an identified home area of the home was missing one float PSW.

During the inspection PSW #169, indicated that on an identified date in June 2019, an identified home area was missing one PSW staff and there was no time to give morning nourishments to the residents at the scheduled nourishment time.

The home's nursing department staffing plan on an identified date in June 2019, did not provide for a staffing mix of personal care staff that was consistent with the residents' #011, #012, #013, #014, #015, #016, #017, #018, #019, #020, #021, #022, #023, #024,# 025, #026 and #027 in an identified home area assessed care and safety needs related to providing morning nourishments to the residents.

B. Review specified forms indicated that on an identified date in July 2019, no morning nourishments were provided to residents' #035, #036, #037, #038, #039, #040, #041, #042, #043, #044, #045, #046, #047, #048 and #049 in an identified home area.

Review plan of care identified that resident #035, #036, #037, #038, #039, #040, #041, #042, #043, #046, #047, #048 and #049 were all at nutritional risk.

Review of specified report dated an identified date in July 2019, and interview with staff #170 indicated that an identified home area of the home was missing one PSW.

During the inspection PSW #170 indicated that on an identified date in July 2019, an identified home area was missing one PSW staff and there was no time to give morning nourishments at the scheduled nourishment time.

The home's nursing department staffing plan on an identified date in July 2019, did not provide for a staffing mix of personal care staff that was consistent with the residents' #035, #036, #037, #038, #039, #040, #041, #042, #043, #044, #045, #046, #047, #048 and #049 in an identified home area assessed care and safety needs related to providing morning nourishments to the residents.

C. Review specified forms indicated that on an identified date in August 2019, no morning nourishments were provided to residents' #010, #028, #029, #030, #031, #032, #033 and #034 in an identified home area.

Review plan of care identified that resident #010, #028, #029, #030, #031, #032, #033 and #034 were all at nutritional risk.

Review of specified report dated an identified date in August 2019, and interview with staff #170 indicated that an identified home area of the home was missing one PSW.

During the inspection PSW #133 indicated that on an identified date in August 2019, an identified home area was missing two PSW staff on specified shift until an identified time and no morning nourishments were provided to the residents due to staff shortage.

The home's nursing department staffing plan on an identified date in August 2019, did not provide for a staffing mix of personal care staff that was consistent with the residents' #010, #028, #029, #030, #031, #032, #033 and #034 in an identified home area assessed care and safety needs related to providing morning nourishments to the residents.

5. The home's staffing plan on an identified date in September 2019, did not meet the residents' assessed care and safety needs related to bathing.

Observation of resident care and interviews with PSWs' #136, #137, #138, and #139 on an identified date in September 2019, identified that there was a staff shortage for specified shift in identified home areas. They indicated that they had two PSWs on each side, instead of the regular complement of three PSWs. They identified that baths and showers could not be provided to residents #050, #051, #052, and #053, who were scheduled to be bathed, as a result of being short staffed; the residents were given bed baths instead.

Observation of residents' care and interviews with PSW #140 and PSW #142 during the inspection on an identified date in September 2019, identified that there was a staffing shortage on the day shift in an identified home area. They indicated that they had two PSWs on each side and one PSW floating between the identified home areas, instead of the regular complement of three PSWs. Staff #140 identified that they did not complete the scheduled shower for resident #054, as they did not have enough time, and that the resident was provided a bed bath instead.

A. A review of resident #050's records, identified that they were to be bathed twice a week, and that they preferred to have baths.

B. A review of resident #051's records, identified that they were to be bathed twice a week. An interview with RPN #146 identified that the resident preferred to have showers.

C. A review of resident #052's records, identified that they were to be bathed twice a week, and that they preferred to have showers.

D. A review of resident #053's records, identified that they were to be bathed twice a week, and that they preferred to have showers.

E. A review of resident #054's records, identified that they were to be bathed twice a week. An interview with RPN #146 identified that the resident preferred to have showers.

During an interview with DOC #107, they acknowledged that residents #050, #051, #052, #053, and #054 were not given their preferred method of bathing and this preference was also not made up during the week. It was identified that it was an expectation that residents were bathed by the method of their choice, during their scheduled bath days.

The home's nursing department staffing plan on an identified date in September 2019, did not provide for a staffing mix of personal care staff that was consistent with the residents' #050, #051, #052, #053, and #054 assessed care and safety needs related to bathing preferences.

6. The home's staffing plan on an identified date in September 2019, did not meet the residents' assessed care and safety needs related to monitoring of residents' #063 and #064 during meals.

On an identified date in September 2019, during breakfast observation in an identified home area, there were two PSWs available in the home area and it was confirmed during the inspection by staff #109 that there was one float PSW missing during specified shift in an identified home area.

On an identified date in September 2019, during an identified period of time, it was observed that 16 residents had their breakfast in an identified dining room with no PSW staff present in the dining room. During this period of time, it was observed by Inspector #632 that two PSWs provided morning care to the rest of nine residents, who were still in their rooms. During breakfast observation on an identified date in September 2019, RPN #161 was standing beside their medication cart, located outside of the dining room, dispensing medications to the residents. Resident #064 was observed feeding breakfast to resident #063 with the spoon.

Staff #161 indicated that they did not see that resident #063 was fed by resident #064 and confirmed that it was not safe for resident #063.

A review of care plan for resident #063 indicated that resident #063 was at specified nutrition risk and had a specified risk related to an identified condition. The resident required specified assistance by one staff at identified period of the day.

The home's nursing department staffing plan, on an identified date in September 2019, did not provide for a staffing mix of personal care staff that was consistent with the residents' #063 assessed care and safety needs related to monitoring of residents' #063 and #064 during breakfast.

7. The home's staffing plan on an identified date in September 2019, did not meet the residents' assessed care and safety needs related to receiving one to one supplementary staffing on specified shift.

Interview with PSW #150 and RPN #145 identified that they were both working on specified shift on an identified date in September 2019, in an identified home area. They indicated that there was shortage of staff, which resulted in no one to one supplementary PSW staffing for resident #069 and resident #070.

A review of resident #069's records, identified that the resident exhibited specified behavior. The resident's care plan indicated that the one to one was initiated on an identified date in August 2019, and was to be in place during specified shifts.

A review of resident #070's records, identified that the resident exhibited specified behavior. The resident's care plan indicated that the one to one was initiated on an identified date in August and was to be in place during specified shifts.

Interview with Staffing Clerk #166 identified that the two one to one supplementary PSW staff scheduled for the specified shift in an identified home area, were pulled from their one to one assignment to other home areas due to staffing shortages.

DOC #101 and DOC #107 confirmed that resident #069 and resident #070 both had one to one supplementary staffing. They acknowledged that resident #069 and resident #070 did not receive their one to one supplementary staffing on specified shift, on an identified date in September 2019, as per their care plan.

The home's nursing department staffing plan on an identified date in September 2019, did not provide for a staffing mix of personal care staff that was consistent with

the residents' #069 and #070 assessed care and safety needs related to receiving one to one supplementary staffing on specified shift (748). (123)

2. The licensee failed to ensure that the staffing plan included a back-up plan for personal care staffing that addressed situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, could not come to work.

A complaint log #016112-19 (IL-69390-HA) was submitted to the MOLTC outlining staffing concerns in the home.

The licensee's staffing plan package "Staffing Plan - St. Joseph's Villa Long-Term Care" was reviewed. The documentation did not include a back-up plan for when the home was short-staffed. A separate document, not part of the staffing plan package, was provided, titled "Prioritizing a Floor and a Half", outlining the process for registered staff to follow, when registered staff were working short and needed to cover one half of another unit. A memo was also sent out to registered staff on an identified date in September 2018, outlining this.

There was no documentation outlining the back-up plan for PSW staff. This was confirmed by the Administrator and DOC #101.

Upon interview with registered staff #149, #150, #151, #158 and PSW's #147, #148, it was identified that there was no written back up plan that would direct PSW staff on how to address staffing situations when staff could not come to work. It was identified that staff were implementing their own strategies to deal with the staffing shortage, including but not limited to, not completing bathing or showers as scheduled, and not completing nourishment pass for residents. It was identified that in some instances, it was at the discretion of the PSWs whether or not bathing would be provided to the residents.

The licensee failed to ensure that the staffing plan included a back-up plan for personal care staffing that addressed situations, when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, could not come to work.

This order is made up on the application of the factors of severity (2), scope (3), and compliance history (3). This is in respect to the severity of minimal harm or minimal

risk that identified residents experienced, the scope of this being widespread incident. The home had a level 3 history as they had previous noncompliance to the same subsection of the LTCHA that included:
- VPC issued October 26, 2017 (2017_542511_0011). (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2020(A3)

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. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/19, s. 135. (1) of the LTCHA.

Specifically, the licensee must:

1. Ensure that every medication incident involving residents' #021 and #076 and all other residents is documented, together with a record of the immediate actions taken to assess and maintain the resident's health and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

2. Ensure that all registered staff are provided education related to need complete Medication Incidents Reports for all medication incidents and ensure that a written record of staff attendance is maintained in the home.

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

Grounds / Motifs :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

The review of Medication Administration audits of medications, administered over one hour after they were scheduled to be administered/late, was conducted and included the following results:

On an identified date in August 2019, during specified shift, 69 residents in the home were noted to have received their medications over one hour past the scheduled time of administration/late.

On an identified date in August 2019, during specified shift, 74 residents in the home were noted to have received their medications over one hour past the scheduled time of administration/late.

On an identified date in August 2019, during specified shift, 121 residents in the home were noted to have received their medications over one hour past the scheduled time of administration/late.

ADOC #103 confirmed that Medication Incident reports were completed by the staff, when medications were administered over one hour after they were scheduled to be administered. They also confirmed that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

The Inspector and DOC #107 reviewed the home's Medication Incidents Analysis and Trends from an identified period in June to August 2019, and it was noted that there were only 30 Medication Incident reports documented for that period.

DOC #107 confirmed that in some instances, where one resident was administered the medication of another resident in error, Medication Incident report was not completed for the resident, who did not receive their medications as a result. They also, confirmed every medication incident involving a resident was not documented together with a record of the immediate actions taken to assess and maintain the

resident's health, related to the late administration of medications, related to the late administration of medications.

The home's Medication Incident records were reviewed. It was noted that on an identified date in June 2019, at an identified time, RPN #161 administered the wrong medications to resident #053. The resident, the resident's SDM and the physician were informed of the incident. The physician gave orders that the resident's vital signs were to be checked frequently and their health status was to be monitored. There was no Medication Incident report related to resident #075 found in the home's Medication Incident records.

It was noted that on an identified date in May 2019, resident #078 was administered the wrong medication. The resident, the SDM and the physician were notified. The physician ordered the staff to monitor the resident's vital signs. Environmental, staffing or workflow problem was noted to have been the number one factor and the detail section listed workload. There was no Medication Incident report related to the resident, who did not receive their medication as a result of the incident found in the home's Medication Incident records.

2. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the the Medical Director.

The home's Medication Incident reports were reviewed, which noted that resident #021 was involved in a medication incident, which was not reported to the home's Medical Director. The incident, dated on an identified date in June 2019, noted that resident #076 was involved in a medication incident, which was not reported to the home's Medical Director; medication incident, dated on an identified date in July 2019, noted that resident #076 was involved in a medication incident, which was not reported to the home's Medical Director.

DOC #101 reported that the staff usually notified the attending and/or on-call Physicians of residents' medication incidents at the time of the incident. In some instances, the Medical Director was the also the resident's attending physician. However, if the Medical Director was not a resident's attending physician, they were not notified of a medication incident until they attended the Medication Management Committee meetings. At those meetings, all the Medication Incident reports for the quarter were reviewed. DOC #101 confirmed that the incidents noted above were

not reported to the Medical Director when they occurred.

The home's Medication Management Committee Minutes were reviewed and it was noted that the Medical Director was not present.

The home did not ensure that every mediation incident, involving a resident, was reported to the Medical Director.

This order is made up on the application of the factors of severity (2), scope (3), and compliance history (3). This is in respect to the severity of minimal harm or minimal risk that identified residents experienced, the scope of this being widespread incident. The home had a level 3 history as they had previous noncompliance to the same subsection of the LTCHA that included:
- WN issued October 26, 2017 (2017_542511_0011). (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2019(A1)

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

(A2)(Appeal/Dir# DR# 131)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 005 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

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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

(A2)(Appeal/Dir# DR# 131)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 006

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

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/19, s. 131. (2) of the LTCHA.

Specifically, the licensee must:

1. Ensure that drugs are administered to residents' #074 and #076 and all other residents in accordance with the directions for use specified by the prescriber.

2. Conduct an audit to ensure that drugs are administered to residents' #074 and #076 and all other residents in accordance with the directions for use specified by the prescriber.

3. Keep documentation records of the audits conducted to ensure that drugs are administered to residents' #074 and #076 and all other residents in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

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

A. The home's Medication Incident records were reviewed, and it was noted that on an identified date in June 2019, at identified time, RPN #161 administered medication to resident #074. RPN #161 did not sign the Medication Administration Record (MAR) at that time.

Minutes later, it was noted that RPN #180 administered medication again to resident #074 and signed the MAR record. RPN #161 informed RPN #180 that they administered the medication earlier but did not have a chance to sign the MAR and therefore the medication was administered twice. The resident, the resident's SDM and the physician were notified.

RPN #161 was interviewed and confirmed the information and noted above. RPN #180 and DOC #107 confirmed the accuracy as documented in the Medication Incident record.

On the same identified date, RPN #179 administered the wrong medication to resident #074. RPN #179 provided a specified intervention to resident #074. The resident, the resident's SDM and the physician were notified. The physician gave orders to hold the next scheduled dose of their medication and the staff were to monitor the resident's specified parameters.

RPN #179 and DOC #107 confirmed the accuracy of the information noted above.

The licensee failed to ensure that drugs were administered to resident #074 in accordance with the directions for use specified by the prescriber.

B. The home's medication incident records were reviewed and it was noted that on an identified date in June 2019, RPN #180 administered the wrong medication to resident #076. The resident, the resident's SDM and the physician were notified.

The Medication Incident record also indicated that on an identified date in July 2019, RPN #181 noted that resident #076 received the wrong medication. The medication was ordered on an identified date in June 2019, for one day only, as there was no another medication available. The medication remained in the resident's medication drawer since that time and it was half empty on an identified date in July 2019, when RPN #181 noticed the medication error. Registered staff checked the resident's parameters and they were within acceptable range. The resident, the resident's SDM and the physician were notified.

RPN #181 discarded the medication and monitored the resident's parameters.

RPN #181 and DOC #107 confirmed the accuracy of the information noted above.

The licensee failed to ensure that drugs were administered to resident #076 in accordance with the directions for use specified by the prescriber.

C. The home's Medication Incident records were reviewed. It was noted that on an identified date in July 2019, the Staff Educator, registered staff #174, discovered an unopened medication package containing resident #082's specified medications for that day, in the medication cart after administering resident's specified medications. The resident was assessed and there was no effects from missing the medication. It was noted the resident's SDM was notified however, there was no information/ blank, indicating the Medical Director/physician was notified.

The Mediation Audit Report, was reviewed and it was noted that resident #082's medications were not documented as being administered.

The licensee failed to ensure that drugs were administered to resident #082 in accordance with the directions for use specified by the prescriber.

D. It was noted that on an identified date in July 2019, the Staff Educator, registered staff #174, noticed resident #083's specified medication package in the medication drawer at identified time. The resident showed no effects of missing the medication pass. It was noted that the resident's SDM was notified however, there was no information/ blank space, indicating the Medical Director/physician was notified.

Another Medication Incident report noted that on an identified date in July 2019, the Staff Educator, registered staff #174, noticed at identified timer that resident #083 had not received their specified medication. The resident did not seem to have any negative effects as a result. Interventions were noted to be: educating the nursing team on medication delivery skills to prevent the events from happening.

The Mediation Audit Report, Missed Documentation, was reviewed and it was noted that on an identified date in July 2019, resident #083's, at identified time, medications were not documented as being administered. There were no specified medications listed in the Mediation Audit Report, Missed Documentation, for resident #083.

The licensee failed to ensure that drugs were administered to resident #083 in

accordance with the directions for use specified by the prescriber.

E. It was noted that on an identified date in July 2019, the Staff Educator, registered staff #174, found that resident #084's specified medications were not administered to the resident. The resident was assessed and there was no effect noted to the resident since the missed medications. The resident and their SDM were notified. There was no indication the Medical Director/physician was notified.

A separate medication of the same date at the same time indicated the resident's specified medications were not signed for. Interventions were noted to have been: counsel registered staff to check MAR/Treatment Administration Record (TAR) records an ensure they sing for the medications. Unknown if given. It was noted that the SDM was not notified. There was no documentation to indicate that the Medical Director/physician was notified.

The Mediation Audit Report, Missed Documentation, was reviewed and it was noted that on an identified date in July 2019, resident #084's specified medications were not documented as being administered.

DOC #107 confirmed the accuracy of the information as documented in the home's Medication Incident records.

The licensee failed to ensure that drugs were administered to resident #084 in accordance with the directions for use specified by the prescriber.

This order is made up on the application of the factors of severity (2), scope (3), and compliance history (3). This is in respect to the severity of minimal harm or minimal risk that identified residents experienced, the scope of this being widespread incident. The home had a level 3 history as they had previous noncompliance to the same subsection of the LTCHA that included:
- VPC issued July 13, 2018 (2018_689586_0014);
- VPC issued November 10, 2017 (2017_569508_0013);
- VPC issued October 26, 2017 (2017_542511_0011). (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2019(A1)

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

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:

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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

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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.

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

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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

Order(s) of the Inspector

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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 17th day of June, 2020 (A3)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by STACEY GUTHRIE (750) - (A3)

Ontario

Ministry of Long-Term Care

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