Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 05, 2019	2018_668543_0020 (A2)	015358-18	Resident Quality Inspection

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 4J3

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

Amended by TIFFANY BOUCHER (543) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested a change in the compliance due date.

Issued on this 5 th day of February, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Amended by TIFFANY BOUCHER (543) - (A2)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 10-14, 17-21, 24-28 and October 1-3, 2018.

Additional intakes inspected during this Resident Quality Inspection (RQI)

included:

Three critical incidents the home submitted to the Director related to Abuse;

Two critical incidents the home submitted to the Director related to Responsive Behaviours;

Three critical incidents the home submitted to the Director related to Falls;

Three critical incidents the home submitted to the Director related to Medication Administration;

Two critical incidents the home submitted to the Director related to Infection Prevention and Control;

Two critical incidents the home submitted to the Director related to unexpected deaths; and

One critical incident the home submitted to the Director related to Neglect and Nursing and Personal Support Services.

Two complaints that were submitted to the Director related to multiple care concerns;

Three complaints that were submitted to the Director related to Abuse;

One complaint that was submitted to the Director related to Responsive Behaviours;

One complaint that was submitted to the Director related to Nutrition and Hydration;

One complaint that was submitted to the Director related to Falls; and

One complaint that was submitted to the Director related to Abuse and Staffing concerns.

One follow-up related to the LTCHA 2007, s. 19, related to the Prevention of Abuse and Neglect, compliance order (CO) #001 from inspection report #2018_616542_0010;

One follow-up related to the LTCHA 2007, s. 6 (7), related to Plan of Care, CO #001 from inspection report #2018_616542_0009;

One follow-up related to the LTCHA 2007, s. 20 (1), related to the Prevention of Abuse, Neglect and Retaliation Policy, CO #002 from inspection report

#2018_616542_0009;

One follow-up related to O. Reg. 79/10, s. 31 (1), related to Nutrition and Hydration, CO #003 from inspection report #2018_616542_0009;

One follow-up related to O. Reg. 79/10, s. 71 (3), related to Nursing and Personal Support Services, CO #005 from inspection report #2018_616542_0009; and

One follow-up related to O. Reg. 79/10, s. 33 (1), related to Bathing, CO #004 from inspection report #2018_616542_0009.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Long-Term Care Nursing Consultant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Office Manager, Lead Staff Educator, Social Worker, Maintenance staff, Physiotherapist, Dietary Aide, Labour Relation Officer, PSW Union representative, residents and families.

The inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, internal investigations, nursing and PSW union documentation and policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **14 WN(s)**
- **4 VPC(s)**
- **8 CO(s)**
- **5 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 71. (3)	CO #005	2018_616542_0009	542

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a designated staff member to co-ordinate the infection prevention and control program with education and experience in infection prevention and control practices including: a) infectious disease, b) cleaning and disinfection, c) data collection and trend analysis, d) reporting protocols and, e) outbreak management.

Two Critical Incident (CI) reports were submitted to the Director outlining two separate reportable outbreaks. The first report was submitted to the Director in January, 2018, indicating that there were three resident exhibiting signs and symptoms of an infection. The second CI report was submitted to the Director in April, 2018, indicating that seven residents were exhibiting signs and symptoms of an infection.

Inspector #542 reviewed the home's information regarding the above two outbreaks. Inspector #542 proceeded to interview the LTC Consultant #101 regarding the home's Infection Prevention and Control Lead (IPAC). They indicated that the home did not have a lead for the program with education and experience in infection prevention and control practices. The LTC Consultant #101 indicated that the current Director of Care and the Assistant Director of Care, along with themselves were sharing the role. [s. 229. (3)]

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. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,
(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and O. Reg. 79/10, s. 213 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section, had at least three years of experience working as a registered nurse in a managerial or supervisory capacity in the health care setting.

During the course of the inspection, a concern was brought forward to Inspector #543, related to the qualifications and experience of the Director of Care hired in the home.

Inspector #543 reviewed a memorandum posted in the home, that indicated that DOC #102 was the home's new Director of Care; effective on a specific date in 2018.

Inspector #543 reviewed DOC #102's personnel file, which contained their Certificate of Registration with the College of Nurses of Ontario that identified a registration date from 2016.

Inspector #543 interviewed LTC Consultant #101 who verified that DOC #102 was registered with the College of Nurses of Ontario on a date in 2016.

Inspector #543 reviewed the requirements under the Long Term Care Homes Act, 2007 and the Ontario Regulations 79/10, with the LTC Consultant #101 who verified that they were not meeting the requirements and that it needed to be addressed. [s. 213. (4) (b)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 002

WN #3: 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 has failed to ensure that each resident of the home was 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.

Inspector #542 conducted a Follow Up Inspection to Compliance Order (CO) #004 served to the licensee on June 19, 2018, under inspection report #2018_616542_0009. The CO required the home to be compliant with O. Reg 79/10, s. 33. (1) by July 30, 2018.

Inspector #542 reviewed the staffing assignment from a specific date in September, 2018, from a specific home area. According to the documentation, the home was short four PSW shifts on the evening shift. The unit had a regular home PSW and an agency PSW covering that unit.

A) A review of the bathing assignment from a specific home area, revealed that resident #037 and #038 were scheduled to have their bath/shower at a specific

time and on a specific date in September, 2018.

Inspector #542 reviewed the Point of Care (POC) documentation for resident #037 and #038 and could not locate any information regarding the completion of their bath/shower from that specific date in September, 2018.

Inspector #542 completed a review of resident #037's care plan, located on PointClickCare (PCC); it was documented that they preferred to be bathed at a specific time of day and that they would be showered twice a week.

Inspector #542 reviewed resident #038's care plan which indicated that they preferred to have a bath at a specific time of day and that they would participate in bathing twice a week.

B) Inspector #542 completed a review of resident #042's POC charting from an evening shift on a specific date during the inspection and noted that PSW #149 had documented that the "activity did not occur." The progress notes did not contain any further information regarding resident #042's bath/shower.

Inspector #542 reviewed resident #042's care plan which indicated that they were to receive a bath twice a week, at specific times.

C) Inspector #542 completed a review of the POC charting located on PCC for resident #043, it was documented under the bathing section, "not applicable."

Inspector #542 reviewed the progress notes located on PCC and was unable to locate any documentation to support why the bath/shower was "not applicable." The care plan for resident #043 identified that they preferred their bath at a specific time and on two specific days of the week.

Inspector #542 reviewed the home's staffing assignment from an evening shift on a specific date during the inspection and noted that the home was short five PSWs.

D) Inspector #542 reviewed the POC charting for resident #026 regarding bathing. It was documented that the "activity did not occur" and it was documented in the progress notes that staff were unable to complete resident #026's bath on a specific shift.

Inspector #542 reviewed the bathing assignment which indicated that resident #026 was to receive their bath/shower on a specific date during the inspection, at a specific time.

Inspector #542 reviewed resident #026's most recent care plan located on PCC and noted that they were to be bathed twice a week with the assistance from staff.

E) Inspector #542 completed a review of resident #044's care plan, which identified that they went to bed at a specific time of day.

Inspector #542 reviewed the 24 hour reports on PCC for each unit and located documentation that indicated that resident #044 and #045 had not received their scheduled baths/showers due to staff shortages and time restraints. The bathing assignment for the home area, identified that both residents were to have their shower/bath on a specific date, on a specific shift during the inspection.

Inspector #542 reviewed resident #044's care plan, which identified that they were to have a bath twice a week.

Inspector #542 reviewed resident #045's care plan, which identified that they were to be bathed twice a week, on specific days of the week.

Inspector #542 interviewed PSW #149, who worked on the dates the residents were to be bathed, and indicated that they were short staffed. PSW #149 indicated that the bath/shower for resident #042 was not completed as a result of being short staffed. They further indicated that resident #043 also did not receive their scheduled bath that shift.

Inspector #542 interviewed PSW #150 who indicated that on a day during the inspection, they worked short on the home area and that a bath/shower was not completed for resident #026.

Inspector #542 interviewed RPN #134 who was working on a day in September, 2018, on a specific home area, during a specific shift. RPN #134 indicated that they did not have a full complement of PSWs and did not believe that they were able to complete all of the assigned baths/showers.

RN #125 informed Inspector #542 and #543 that the home was short staffed on the previous evening shift. RN #125 indicated that they did not believe that the

staff were able to complete the baths/showers for the residents during that shift. [s. 33. (1)]

Additional Required Actions:

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

DR # 005 – The above written notification is also being referred to the Director for further action by the Director.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Inspector #542 conducted a Follow Up inspection to Compliance Order (CO) #003 served to the licensee on June 19, 2018, under inspection report #2018_616542_0009. The CO required the home to be compliant with O. Reg 79/10, s. 31 (1) by July 30, 2018. In addition, several complaints were received by the Director, from family, and residents during the course of the inspection. The complainants outlined concerns related to the shortage of staff and how it was

affecting the care of residents in the home.

A) Documentation review:

Inspector #542 requested that the scheduling and payroll departments provide documents that identified when the home did not have a full complement of PSWs from August, 2018, to September, 2018. Together, Inspector #542 and the Director of Care (DOC) reviewed the documentation, they confirmed where the home was without a full complement of staff; the following was verified:

During the month of August 2018, the home failed to meet their planned staffing contingency on 27 out 31 days, or 87 percent of the days in the month. The staffing deficiency in the month of August, 2018, totaled 183 missed PSW shifts, with an average of seven PSW vacancies per day. In the month of September, 2018, the home failed to meet their planned staffing contingency on 24 out of 30 days, or 80 per cent of the days in the month. The staffing deficiency in the month of September, 2018, totaled 147 missed PSW shifts, with an average of five PSW vacancies per day.

Inspector #542 interviewed Labour Relations Officer #154 and RN #155. Labour Relations Officer #154 indicated that the RNs were not receiving the resources required to complete resident care. They indicated that the home had been short staffed, causing the RN's to complete medication administration for the residents when they were unfamiliar with this role as the home typically had the RPNs completing that duty. They indicated that RNs had been completing "Professional Responsibility Workload" forms that indicated that the home had been short-staffed. The completed forms indicated that on occasion, the RNs were unable to complete wound dressings and other RN duties, staff were unable to provide care to the residents safely, and the home had agency staff working on units alone where they were not familiar with the residents.

Inspector #542 interviewed union representative #156 who represented PSWs and the RPNs in the home. They provided a copy of the completed, "Workload Review" forms filed to the home from the PSWs, RPNs and housekeeping staff. Inspector #542 completed a review of the completed forms and found, 54 forms were completed during August and September, 2018, outlining that the home was short staffed. A further review of the completed forms identified that at times, PSWs were working alone on a unit, were unable to provide continence care for residents that required two staff members, described unsafe working conditions,

were unable to provide proper care to the residents, were unable to answer call bells and alarms in a timely fashion, and described that residents were being rushed.

Inspector #542 was provided with a document from the Office Manager, dated September 6, 2018, which indicated that the home had numerous PSW positions that remained unfilled. Inspector #542 verified this information with the DOC. Furthermore, there were several RPN position that remained unfilled.

B) Bathing:

O. Reg. 79/10, s. 33 (1), requires that, "Every licensee of a long-term care home 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."

Inspector #542 reviewed the staffing assignment from a date in September, 2018, from a specific home area that was provided by the payroll department. According to the documentation, the home was short four PSW shifts during a specific shift.

A review of the bathing assignment from a home area, revealed that scheduled baths or showers were not provided during a specific shift, as a result of being short staffed. RN #125 informed Inspector #542 and #543 that the home was short staffed on the previous evening shift. RN #125 indicated that staff were unable to complete the baths/showers for the residents on that shift. Two days later, Inspector #542 reviewed the 24 hour reports on PCC for each unit and located documentation that indicated that resident #044 and #045 did not receive their scheduled baths/showers due to staff shortages and time restraints. The bathing assignment for the home area, identified that both residents were to have their shower/bath during the specific shift. See WN #3 for further detail.

C) Feeding:

O. Reg. 79/10, s. 73 (2) (a), requires that, "The licensee shall ensure that, no person simultaneously assists more than two residents who need total assistance with eating or drinking."

On a day during the inspection, Inspector #542 observed a home area during a meal service. Inspector #542 observed one PSW serving food to the residents'

while feeding other resident's their meal in between. The Inspector was informed by the RPN that the unit did not have a full complement of PSW staff.

On a different day during the inspection, Inspector #543 was observing a meal service on a home area and noted that they were short one PSW shift. Inspector #543 observed a PSW going back and forth between tables to feed the residents. The RN on the unit was assisting three residents at one table (a resident was moved to this table in order to have someone to feed them).

On the same day as Inspector #543, Inspector #542 observed a different home area during the meal service. A dietary aide was observed providing the residents their fluids and indicated that they were running late and that they were trying to help the staff as they were working short. RPN #144 indicated that they were required to move a resident from their assigned table to another table in the dining room where a staff member was present due to short staffing.

D) Plan of care:

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

On a day during the inspection, Inspector #542 and #543 observed on a specific home area that was short staffed. The Inspectors observed resident #044 up in the common area without pants, sitting directly across a co-resident. PSW #151 indicated that the resident was due to be bathed on that day, they were short staffed and that was why they were not wearing pants. Inspector #542 completed a review of resident #044's care plan, which identified that they went to bed at a specific time (one and half hours earlier than when the resident was observed). See WN #5, -5 for further detail.

Inspector #542 and #543 proceeded to another home area and found seven residents still up in the common area. Residents were observed sleeping. A PSW came and indicated that resident #046 was going to be taken for their bath. Resident #046's care plan indicated that they preferred to go to bed at a specific time (between one and half to two hours before the resident was observed), but was still up. Resident #047 was observed falling asleep. Inspector #542 reviewed resident #047's care plan which identified that they preferred to be transferred to bed at a specific time (between two to three hours before the resident was observed). Resident #013 was also observed up in the common area, a review of

their care plan indicated that they went to bed at a certain time (between one and a half and two and half hours before the resident was observed). See WN #5, -5 for further detail.

Inspector #542 interviewed RPN #144, who was working on a specific home area. RPN #144 indicated that the home area was short staffed and typically the residents would all be in bed at that time.

On a date during the inspection, resident #041 sustained a fall that resulted in injuries. Inspectors #543 and #542 interviewed the DOC and the ADOC who indicated that resident #041 required a specific frequency of monitoring and that did not occur at the time of the fall. See WN #5, -4 for further detail.

E) Nursing and Personal Support Services:

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

Inspector #542 and Inspector #543 were observing a home area. Resident #032 approached the Inspectors and indicated that they wished to speak to the Inspectors. Resident #032 indicated that they were experiencing pain to a certain area of their body as they were left for too long and that they frequently had to wait a long time for assistance. Resident #032 identified that staff typically assisted them around a preferred time as this was when the staff asked the resident and if the resident refused at that time, then they would have to wait until much later. They also indicated that the home was frequently short staffed and that they did not know how much more they could take. Resident #032 indicated that often after one meal they were placed in a common area until around the next meal. Before that next meal, resident #032 would request assistance with an activity of daily living; however, staff would tell them that they would have to wait as they did not have the time to transfer them back before the meal service.

On a specific date during the inspection, Inspector #542 observed resident #034 requiring assistance. Inspector #542 observed that the home area was short staffed as a PSW was transferred to another unit where they were also short staffed. Inspector #542 observed staff enter resident #034's room, 30 minutes later.

Inspector #543 interviewed PSW #145 who indicated that on the date resident #034 was observed requiring assistance, the PSWs were not able to complete their last rounds as a result of having to complete their charting. They indicated that it was a result of not having adequate staff scheduled for that shift.

F) Duty to Protect:

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

O. Reg. 79/10 defines neglect as "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 jeopardized the health, safety or well-being of one or more residents."

Inspector #542 reviewed the home's staffing plan specific to the previous shift, and noted that the home was short four PSWs.

Inspector #542 interviewed the PSW staff who came on shift after the home was short staffed on the previous shift, from a specific home area. PSW #141, #157 and #158, indicated that numerous residents were found incontinent with soiled bedding; as well, some residents that were to wear incontinent products, had nothing on. One resident had altered skin integrity as a result of being incontinent. Another resident was still dressed in clothing from two shifts previous which was soiled, along with their bedding.

Inspector #542 interviewed PSW #149, who worked that specific shift, on a certain home area. PSW #149 indicated that no other PSWs were working on that unit as they were short staffed. They identified that they were unable to provide care for multiple residents for the whole eight hour shift, as a result of short staffing.

Inspector #542 reviewed the CI report that was submitted to the Director, outlining staff to resident neglect. The report indicated that multiple residents had not received care during a shift, as the PSW was working alone due to short staffing. See WN #6 for further detail. [s. 31. (1) (b)]

Additional Required Actions:

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

DR # 004 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspectors conducted a Follow Up inspection to Compliance Order (CO) #001, served to the licensee on June 7, 2018, under inspection report #2018_616542_0009. The CO required the licensee to ensure they were compliant with LTCHA, 2007 S.O. 2007, c.8, s. 6 (7) by July 30, 2018.

A complaint was submitted to the Director regarding care concerns of resident #022. The complaint identified that the resident had a fallen on a date in November, 2017, which the family was not made aware of and that care was not being implemented properly.

Inspector #638 reviewed resident #022's health care records and identified a progress note created, by RPN #104 which indicated that the resident was found by a PSW to be seated in an unsafe manner. The PSW was unable to reposition

the resident and had to manually lower the resident to the floor and lift them using a mechanical lift. The PSW reported to the RPN that the resident's interventions were not implemented at the time of the incident. The resident was assessed and noted to have an injury.

Inspector #638 reviewed resident #022's care plan and identified in the care plan in effect at the time of the incident the resident was to have specific interventions implemented to alert staff and prevent falls. The Inspector reviewed the resident's "PSW documentation in Daily Care Flow sheet supports MDS 2.0 Coding" and identified the record had no documentation from the day the resident fell, identifying that the resident's specific interventions were implemented.

In an interview with Inspector #638, PSW #110 indicated that in 2017, direct care staff used paper documentation to identify the care and interventions implemented for a resident. The PSW stated that if a resident had a specific intervention that they would document the intervention. Upon reviewing resident #022's, "PSW documentation in Daily Care Flow sheet supports MDS 2.0 Coding" record, from specific dates between October and November, 2017, the PSW indicated that if the resident required an intervention, direct care staff were to ensure that it was implemented and document the care provided.

During an interview with Inspector #638, RPN #104 indicated that they were working at the time of the incident. The RPN stated the PSW found the resident seated in an unsafe manner. The RPN was unable to recall the specific interventions the resident required, but indicated that the resident was at a specific risk for falling and believed they had an intervention that was supposed to be implemented.

Inspector #638 interviewed RPN #109 who indicated that PSWs were responsible for implementing and documenting interventions as identified within the resident's care plan. The RPN stated that the home previously used a paper record for documenting care and direct care staff had to ensure that the interventions in the care plan were implemented and documented. The RPN indicated that staff were required to follow the tasks and interventions laid out within the resident's care plan.

The home's policy titled "Care Planning – RC-05-01-01" last updated April 2017, indicated that "a care plan is a guide that directs care that is provided to the resident. Individual resident care plans reflect specific information about a

resident including identification of individual problems and their expected outcomes, interventions required to produce expected outcomes, and clinical care requirements with proposed time limits for implementation".

In an interview with Inspector #638, the DOC and ADOC stated that staff referred to a resident's care plan and kardex for specific interventions. The DOC indicated that care was supposed to be provided as outlined within the plan. The Inspector reviewed resident #022's, progress note with the DOC and ADOC. When asked if they would have expected staff to implement the interventions as laid out within the care plan, they stated "absolutely" and if not they would have expected documentation to support why the interventions were not implemented. [s. 6. (7)]

2. Resident #002 was identified during the inspection as having impaired skin integrity.

Inspector #542 reviewed resident #002's health care record, related to their impaired skin integrity. Inspector #542 reviewed the weekly wound assessments which indicated that resident #002 had impaired skin integrity to several parts of their body. A review of the current care located on PCC, under the focus heading, "Altered Skin Integrity" it was documented that resident #002 was to have specific devices applied.

On two separate dates, Inspector #542 observed resident #002 in their room, without the specific devices applied.

Inspector #542 interviewed RPN #140 who indicated that resident #002 had impaired skin integrity. RPN #140 indicated that resident #002 frequently had areas of altered skin integrity and that one of the interventions was to ensure that they had a specific device applied at all times. [s. 6. (7)]

3. A complaint was submitted to the Director regarding an incident which occurred on a date July, 2018, where resident #039 was cared for in an improper manner.

Inspector #638 reviewed PSW #147's "Discipline Notice", related to the incident. The notice identified that while assisting resident #039, the PSW did not provide care according to the resident care plan. The notice identified that it was required that staff check the care plan before providing care.

The Inspector reviewed resident #039's care plan and identified that the resident

was supposed to be transferred using a specific assistive device at all times. The care plan also identified that the resident was supposed to be toileted in a specific manner.

In an interview with Inspector #638, PSW #147 indicated that they were working on another unit but noticed the call bell had been sounding for about 20 minutes. The PSW indicated they responded to the resident's bell and assisted the resident. The PSW stated they used to work extensively with resident #039 and they were not aware that the interventions in their care plan had changed. The PSW acknowledged, they did not check the care plan prior to providing care.

In an interview with Inspector #638, the DOC and ADOC stated that staff referred to a resident's care plan and kardex for specific interventions. The DOC indicated that resident care was supposed to be provided as outlined within the resident's plan. [s. 6. (7)]

4. During the inspection two separate incidents of resident #041's Responsive Behaviours were brought forward. On a date in September, 2018, resident #041 was agitated, and was sitting with RPN #119, when they displayed responsive behaviours towards the staff member. Two days later, resident #041 sustained a fall, that resulted in several injuries.

Inspector #543 reviewed this resident's care plan, specifically related to responsive behaviours which identified that the resident was to be provided with a specific frequency of monitoring.

Inspector #543 reviewed resident #041's progress notes, which had a late entry documented, identifying that the resident had fallen and sustained injuries.

The Inspector reviewed the home's Nursing Department Daily staffing sheet, which identified that the unit the resident resided on did not have monitoring scheduled for this resident.

The Inspector interviewed PSW #152 who verified that the resident was started on specific frequency of monitoring, but indicated there was no consistency with the monitoring, and there were times when the monitoring was not provided.

The Inspector interviewed RPN #119 who verified that the home was short staffed that evening, and that the monitoring for this resident was not available and was

not replaced.

Inspector #543 interviewed RPN #153 who verified that resident #041 required specific frequency of monitoring; however, there had not been any consistency with providing the monitoring, as a result of the home being chronically understaffed. The RPN indicated that the resident had a fall, two days after the responsive behaviour incident, at the time of the fall there was no specific frequency of monitoring provided for the resident.

Inspector #543 interviewed RN #125 who verified that on the day the resident fell, the resident was supposed to be provided with a specific frequency of monitoring but was not.

Inspectors #543 and #542 interviewed the DOC and the ADOC. They indicated, that resident #041 was found on the floor after falling. The verified that there was no monitoring present at the time of the resident's fall. [s. 6. (7)]

5. a) On September 20, 2018, Inspector #542 observed resident #034 attempting to stand up. Resident #034 was observed to have a safety device that was improperly applied, rendering the device inoperable. Another safety device was also observed on; however, it was not correctly applied. Inspector #542 observed resident #034 for more than 20 minutes and observed a staff member walk past the resident.

Inspector #542 reviewed the current plan of care located in the binder on the unit. Under the focus heading "Risk for Falls", it was documented that resident #034 was to have a specific safety devices applied to alert the staff and prevent falls.

Inspector #542 interviewed PSW #143, who indicated that resident #034 was to have safety devices.

b) Inspector #542 and Inspector #543 were observing on a home area. Inspector #542 observed resident #033 in the common area in a chair that was not positioned properly, no foot rests were on the chair and the resident's feet were bare. Resident #033 was observed attempting to sit up in their chair and trying to move the chair on numerous occasions, however was unable to do so, as the chair was not positioned properly.

Inspector #542 reviewed resident #033's most recent care plan. Under the foci,

"Falls", it was documented that resident #033 was to have a safety device applied and that staff were to ensure that they had specific type of socks on.

Inspector #542 interviewed PSW #143, who indicated that resident #033 was to be positioned a certain way when they were displaying specific responsive behaviours. They indicated that staff would position the resident's chair back and then put their feet up on a chair and that they were to have specific type of socks on.

c) Inspector #542 and #543 observed on a specific home area that was short staffed. The Inspectors observed resident #044 up in the common area without pants, sitting directly across a co-resident. PSW #151 indicated that the resident was due to be bathed on that day, they were short staffed and that was why they were not wearing pants.

Inspector #542 completed a review of resident #044's care plan, which identified that they required special interventions related to an activity of daily living. It was documented in resident #044's care plan, that they went to bed at a specific time (one and half hours earlier than when the resident was observed).

Inspector #542 and #543 observed a home area, and identified multiple residents in the common area, some of them were asleep. A PSW came and indicated that resident #046 was going to have their bath now.

Inspector #542 reviewed resident #046's care plan, which indicated that the resident's had a preferred bed time.

Resident #047 was observed in the common area, falling asleep.

Inspector #542 reviewed resident #047's care plan which identified that they liked to be transferred to bed at a specific time.

Resident #013 was also observed up in the common area, a review of their care plan indicated that the resident's preferred bed time was at a certain time.

Inspector #542 interviewed RPN #144, who was working on the home area who indicated that the home area was short-staffed and typically the resident's would all be in bed at that time. [s. 6. (7)]

Additional Required Actions:

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and failed to ensure that resident were not neglected by the licensee or staff.

Inspector #542 conducted a Follow Up inspection to Compliance Order (CO) #001 , served to the licensee on June 7, 2018, under inspection report #2018_616542_0010. The CO required the licensee to ensure they were compliant with LTCHA, 2007 S.O. 2007, c.8, s. 19 (1) by July 6, 2018.

O. Reg. 79/10 defines neglect as "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 jeopardized the health, safety or well-being of one or more residents."

A) O. Reg. 79/10, s. 31 (1), requires that, "The licensee ensure that there is an

organized program of personal support services for the home to meet the assessed needs of the residents".

Inspector #542 reviewed the home's staffing plan for a specific shift, and noted that the home was short several PSWs.

Inspector #542 interviewed the PSW staff who came on shift after the home was short staffed that specific shift. PSW #141, #157 and #158, indicated that numerous residents were found incontinent with soiled bedding; as well, some residents that were to wear incontinent products, had nothing on. One resident had altered skin integrity as a result of being incontinent. Another resident was still dressed in clothing from two shifts previous which was soiled, along with their bedding.

Inspector #542 interviewed PSW #149, who worked that specific shift who indicated that no other PSWs were working on that unit as they were short staffed. They identified that they were unable to provide care for multiple residents for the whole eight hour shift, as a result of short staffing.

Inspector #542 reviewed the Critical Incident (CI) report that was submitted to the Director by the licensee, outlining staff to resident neglect. The report indicated that multiple residents did not receive care on a specific shift in September, 2018, as the PSW was working alone due to short staffing. See WN #4 for further detail.

Inspector #542 interviewed the DOC, who indicated that RN #155 and PSW #149 were both disciplined as a result of the neglect of multiple residents.

B) Inspector #542 and #543 were approached by resident #035's family member. They indicated that resident #035 previously resided in the home, however had passed away.

Inspector #542 completed a review of resident #035's health care record. Upon resident #035's admission to the home, it was documented on the physician's orders; that resident #035 had specific Health Care Directives, which identified being transferred to an acute care hospital for treatment.

Inspector #542 reviewed the progress notes located on PCC, which identified the following related to resident #035's health condition over a 12 hour period:

- resident #035 indicated that they were not feeling well. The resident was later found incontinent and refused a meal. A family member asked for a specific medical intervention.

- resident was assisted by their family member as the resident became weak. Vital signs were taken with some abnormal results. Registered Nurse was made aware of the resident's condition. Noted in the Medical Director's book.

- New set of vitals taken and recorded, some abnormal results.

- PSW indicated that the resident was incontinent, noted in calendar to initiate a diagnostic medical intervention later as the resident was too unwell.

- PSW reported that the resident did not appear well. Writer went to check and resident did not look well at all. Called ambulance.

- Writer on way back to resident's room, resident had passed away. No pulse present. Called ambulance and told them no need for them to come anymore.

- Notified POA of the resident's passing.

Inspector #542 reviewed the "on-call" physician's documentation which indicated that they were called regarding an "unexpected death." The physician also documented that no physician was contacted regarding resident #035's illness.

Inspector #542 and #543 were approached by resident #035's family who indicated that they felt that had they been notified of the resident's change in condition, perhaps that could have changed the outcome. The family was very upset, and met with the home's management team, who verified that staff should have informed the family, specifically the resident's substitute decision-maker, of the resident's change in condition. The management team informed the family the RN would no longer be working in the home.

Inspector #542 interviewed the DOC, asked if they felt that the death of resident #035 was unexpected. The DOC indicated that the death was unexpected. The Inspector asked if any of the registered staff had notified the physician of the resident's change in condition prior to their death. According to the documentation, some of the resident's vitals were abnormal. The DOC verified

that nobody had notified the physician.

In a subsequent interview with the DOC, Inspector #542 asked them if any of the staff members notified the family of resident #035 when their health status changed the day prior to their death. The DOC indicated that nobody had contacted the family prior to their death and that they spoke with all of the staff involved, specifically the RN that was working the shift when resident #035 passed away. Inspector #542 asked the DOC if any of the staff notified the physician when resident #035's condition had changed. The DOC verified that the staff notified the physician after the resident had passed away. The DOC indicated that a RN was working on the unit, in the capacity of the RPN on the unit as a result of short staffing, and that the RN would no longer be working in the home. See WN #10 for further detail.

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

i) Resident #041 sustained a fall that resulted in injuries.

Inspector #543 reviewed resident #041's progress notes, which indicated a late entry documented, identifying that the resident had fallen and sustained injuries.

The Inspector reviewed the home's Nursing Department Daily staffing sheet for the date on which the resident fell, which identified that the unit the resident resided on did not have a specific frequency of monitoring scheduled for this resident.

Inspectors #543 and #542 interviewed the DOC and the ADOC. They indicated, that resident #041 was found after falling. They verified that there was no monitoring present at the time of the resident's fall.

ii) On a date in September, 2018, Inspector #542 and #543 observed on a home area, that several residents remained up in the common area of the unit. The Inspectors identified that residents neglected to have their care provided as specified in their plan of care.

Inspector #542 interviewed RPN #144, who was working on that home area, who indicated that the home area was short-staffed and typically the resident's would all be in bed at that time. See WN #5 for further detail. [s. 19. (1)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #7: 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 has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #638 conducted a Follow Up inspection to Compliance Order (CO) #002 , served to the licensee on June 19, 2018, under inspection report #2018_616542_0009. The CO required the licensee to ensure they were compliant with LTCHA, 2007 S.O. 2007, c.8, s. 20 (1) by July 30, 2018.

A complaint was submitted to the Director regarding an incident which occurred on a date in July, 2018, where resident #039 was cared for in an improper manner.

Verbal abuse is defined within the Ontario Regulation 79/10, as any form of verbal

communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Inspector #542, Inspector #543 and Inspector #638 each observed a video recording of resident #039 and PSW #147 responded to the resident's question in a verbally inappropriate manner.

Inspector #638 reviewed PSW #147's "Discipline Notice", related to the incident. The notice identified that while assisting a resident with care, the PSW spoke to resident #039 in a verbally inappropriate manner.

The Inspector reviewed resident #039's health care records and identified in their care plan under the "Mood" foci that the resident required specific interventions related to verbal communication.

In an interview with Inspector #638, PSW #147 indicated that they were working on another unit but noticed the call bell had been sounding for about 20 minutes. The PSW indicated they responded to the resident and stated that their approach was inappropriate

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-01" last updated April 2017, identified verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident. The policy identified examples of verbal abuse as inappropriate tone of voice, abusive language, yelling, swearing, rude, offensive or sexual comments or gestures.

In an interview with Inspector #638, the DOC and ADOC indicated that PSW #147's actions towards resident #039 were not appropriate and that during this incident the PSW was not following the home's policy to promote zero tolerance of abuse. [s. 20. (1)]

Additional Required Actions:

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

DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): 2. An unexpected or sudden death, including a death resulting from an accident or suicide.

A complaint was brought forward to Inspector #542 and #543 while conducting the Resident Quality Inspection (RQI) at the home. A family member (POA) for

deceased resident #035 indicated that they were upset as the home failed to notify them when the residents' health status had changed and then they later passed away.

Inspector #542 completed a review of resident #035's health care record. Upon resident #035's admission to the home, it was documented on the physician's orders; that resident #035 had specific Health Care Directives, which identified being transferred to an acute care hospital for treatment.

Inspector #542 interviewed the DOC, who confirmed that the home should have reported the unexpected death of resident #035 to the Director. [s. 107. (1) 2.]

2. The licensee has failed to ensure that the resident's substitute decision maker, if any , or any person designated by the substitute decision-maker and any other person designated by the resident were promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be notified.

Inspector #542 and #543 were approached by resident #035's family member regarding concerns related to the resident's death. The resident's family indicated that the resident passed away unexpectedly, and that the family was not notified until the staff found the resident deceased. The family had concerns related to the resident's abnormal vital signs prior to their death. The family felt that if they had been notified of the resident's change in condition, perhaps that could have changed the outcome. The family was very upset, and met with the home's management team, who verified that staff should have informed the family, specifically the resident's substitute decision-maker, of the resident's change in condition. The management team informed the family the RN would no longer be working in the home.

Inspector #542 completed a health care record review for resident #035. It was documented, that resident #035 did not feel well; they refused meals. The family requested that the home initiate a medical diagnostic intervention. An assessment was completed by a nurse, which indicated that the resident had an abnormal vital sign reading prior to their death. Later, another assessment was completed which showed that resident #035's vital signs were abnormal. The RN called the family and notified them that resident #035 had passed away.

Inspector #542 interviewed the DOC, asked if they felt that the death of resident

#035 was unexpected. The DOC indicated that the death was unexpected. The Inspector asked if any of the registered staff had notified the physician of the resident's change in condition prior to their death. According to the documentation, the resident's vital signs were abnormal. The DOC verified that nobody had notified the physician. Inspector #542 then asked if anyone had notified the family about the resident's status, to which the DOC verified that the family was only notified after the resident died. The DOC indicated that they should have notified the family sooner when they charted the resident's change in condition, at the very least, they should have notified the family when they assessed resident #035's vital signs to be abnormal. [s. 107. (5)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): 2. An unexpected or sudden death, including a death resulting from an accident or suicide and that the resident's substitute decision-maker are promptly notified of a serious injury or serious illness of the resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that misuse or misappropriation of a resident's money had occurred or may occur shall report the suspicion and the information upon which it was based to the Director.

Inspector #613 reviewed a CI report that was submitted to the Director on a date in June, 2018, that identified suspected financial abuse between resident #018 and a visitor.

According to the LTCHA, financial abuse is defined as any misappropriation or misuse of a resident's money or property.

A review of the home's investigation file and the documentation in the resident's progress notes; revealed that, Social Worker (SW) #124 had suspected financial abuse from a visitor towards resident #018. The Social Worker had contacted the visitor on this date to advocate on behalf of resident #018 to determine a resolution. It was documented in progress notes that SW #124 had reported the suspected financial abuse to the previous Administrator. The suspicion of financial abuse was not reported to the Director until eight days later.

A review of the homes' policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" last revised on April 2017, indicated that any employee or person who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect would report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at the time. In addition, anyone who suspected or witnessed abuse that caused harm or may cause harm to a resident was to contact the Ministry of Health and Long Term Care (Director) through the Action Line. Management would promptly and objectively report all incidents to external regulatory authorities, including the police if there were reasons to believe criminal code offense had been committed.

During an interview with Social Worker #124, they verified that they had suspected financial abuse, when they had contacted the visitor. SW #124 stated that they had reported their suspicion of financial abuse to the previous Administrator on the same day, after speaking to the visitor and that the Administrator at that time had informed them they would take care of everything. SW #124 stated that the previous Administrator had informed the Director.

During an interview the current Director of Care, they stated that they were not the DOC at the time of the occurrence and that they did not know when the home or who had first suspected financial abuse, but confirmed that it should have been reported when the suspicion first occurred.

During an interview the Acting Administrator, they stated that from their investigation, they were made aware that the former Administrator, had been made aware of the issue and had informed staff that they would take care of it and unfortunately had not reported to the Director until eight days later. The Acting Administrator confirmed that the suspicion of financial abuse should have been reported immediately to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that misuse or misappropriation of a resident's money has occurred or may occur shall report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and residents.

During the inspection concerns were brought forward to the Inspectors related to resident #041's responsive behaviours.

Inspector #543 reviewed resident #041's care plan, specifically related to responsive behaviours towards other residents and identified that the resident's care plan did not indicate such behaviours, nor did the care plan provide for any interventions.

The Inspector reviewed resident #041's progress notes which indicated that on a date in September, 2018, the resident displayed physical responsive behaviours to resident #048.

The Inspector reviewed the resident's "Responsive Behaviour's Debrief" note, completed on the day of the incident, that indicated that the resident entered resident #048's room and displayed physical responsive behaviours towards them.

Inspector #543 reviewed the Physician's progress notes which indicated the following:

-Description of the physical responsive behaviours towards another resident.

-Episodes of a specific type of responsive beahviour. Specific monitoring currently being provided. Staff and other residents at risk.

Inspector #543 interviewed RPN #126 who verified that resident #041 entered resident #048's room and displayed physically responsive behaviours towards them, and that the resident could demonstrate various types of responsive behaviours.

Inspector #543 interviewed RN #125 who verified that resident #041 could demonstrate various types of responsive behaviours and that the resident's care plan did not address various types of responsive behaviours towards other residents.

Inspectors #543 and #542 interviewed the DOC and the ADOC who verified that resident #041's care plan did not identify that the resident demonstrated various types of responsive behaviours towards other residents. They also verified that the resident's care plan did not contain interventions to prevent harmful situations. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and residents, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) A CI report was submitted to the Director on a day in July, 2018, which identified resident #028 received an incorrect dose of medication.

Inspector #638 reviewed resident #028's health care records and identified a revised physician's order, which directed staff to administer a specific dose of medication at a specific time.

The Inspector reviewed resident #028's progress notes and identified a notation made that identified the resident received the wrong dose of medication.

b) A CI report was submitted to the Director on a date in July, 2018, which identified that on a day in June, 2018, RPN #129 administered a double dose of a medication to resident #029.

Inspector #638 reviewed resident #029's health care records and identified a physician's order created on a date in October, 2017, which directed staff to administer a specific dose of medication.

c) A CI report was submitted to the Director on a date in July, 2018, which identified that, resident #030 received their medications prior to the time the medications was ordered to be given.

Inspector #638 reviewed resident #030's health care records and identified three physican orders for the three different medications all to be administered at the same time of day.

The Inspector reviewed resident #030's eMAR and identified that on a date in July, 2018, the resident's 1600 hour dose for the three different medications were documented as "9" ("Other/ See Nurse Notes"). The Inspector reviewed resident #030's progress notes and identified a notation made on a date in July, 2018, which indicated that the resident's 1600 hour medications were missing from the strip pack and the RPN found the empty medication pack in the garbage.

d) A medication incident was selected by the Inspector as part of the medication review and identified an incident which occurred on a date in August, 2018, where resident #031 received an incorrect dose of medication which was not prescribed to them.

Inspector #638 reviewed resident #031 health care records and identified a physician's order created on a date in March, 2018, which directed staff to administer a certain medication at a specific time.

In an interview with Inspector #638, RPN #128 identified that registered staff ensure medication dosage by checking the eMAR and comparing to the medication strips to ensure dosing was correct. The RPN indicated that staff were "absolutely" expected to only administer the prescribed dosage of a medication and a medication incident would have to be completed if the incorrect dosage was administered.

The home's policy titled "The Medication Pass – 3-6" dated February 2017, indicated that each resident receives the correct medication in the correct prescribed dosage, at the correct time and by the correct route.

In an interview with Inspector #638, the DOC and ADOC indicated registered staff were expected to administer medications based on the prescriber's orders and if they weren't it was considered a medication incident which would be identified in a medication incident report. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the resident's mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A complaint was submitted to the Director related to responsive behaviours and the interventions implemented to manage the resident's responsive behaviours.

Inspector #638 reviewed resident #021's health care records and identified a progress note related to a referral dated for a date in June, 2018, which identified that the resident had worsening behaviours since their admission, had been sent to hospital due to their behaviours and had increasing behaviours towards staff. The progress note identified that an assessment had been completed from the referral on a date in July, 2018, and the care plan was to be updated with interventions.

The Inspector reviewed the "Behavioural Assessment" completed on a date in May, 2018, which identified that the resident demonstrated specific behaviours at an identified frequency. The Inspector also reviewed the hospital admission records which indicated that the resident presented on a a specific date, with a change in their condition related to behaviours.

Inspector #638 reviewed resident #021's health care records and progress notes over 39 days, between June, 2018, and July, 2018. The notes identified that the resident demonstrated;

-specific responsive behaviours on six occasions; and
-specific responsive behaviours on five occasions.

The Inspector reviewed resident #021's care plan, in effect during their admission and was unable to identify any foci which identified the resident's potential for specific responsive behaviours.

In an interview with Inspector #638, PSW #110 staff referred to the resident's care plan for resident interventions and responsive behaviours. The PSW indicated that the care plan was used to keep staff aware of a resident's status and needs.

Upon reviewing the resident's health care records with RPN #126, they identified that the resident had specific behaviours. The Inspector reviewed the resident's care plan with the RPN, who indicated that the resident's care plan did not identify they had specific behaviours, and registered staff should have updated the resident's care plan to identify these behaviours when they were identified.

The home's policy titled "Responsive Behaviours – RC-17-01-04" last updated February 2017, indicated that, "the nurse is to ensure that the care plan contained information related to each behaviour observed and includes what the behaviour

actually is and describes, in detail what the behaviour appears like."

In an interview with Inspector #638, the DOC and ADOC stated that registered staff could update a resident's care plan as changes occurred. The DOC identified that resident #021 demonstrated responsive behaviours and the Inspector reviewed the resident's care plan with the DOC and ADOC who indicated that they didn't identify anything regarding the resident's responsive behaviours. The DOC and ADOC indicated that they would have expected staff to identify the resident's responsive behaviours in the plan. [s. 26. (3) 5.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #002 was identified for having impaired skin integrity.

Inspector #542 completed a health care record review for resident #002. The current care plan located on PCC indicated that they had several skin impairments. Inspector #542 reviewed the weekly wound assessments located on PCC and located an assessment that was completed on a date in September, 2018. It was documented that a previous skin impairment had reoccurred for resident #002. Inspector #542 was unable to locate any other assessment that was completed outlining the condition of the skin impairment.

A review of the home's policy, dated February 2017, titled, "Skin and Wound Program: Wound Care Management" indicated that the nurse or wound care lead was to use a specific assessment tool, and that the resident was to be re-assessed weekly.

Inspector #542 interviewed RPN #140, who completed the initial assessment on a date in September, 2018, of the reoccurring skin impairment for resident #002. They indicated that the skin impairment should have been re-assessed weekly after the initial assessment. RPN #140 was unable to locate a completed weekly assessment after a specific date in September, 2018. [s. 50. (2) (b) (iv)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person simultaneously assists more than two residents who need total assistance with eating or drinking.

O. Reg. 79/10, s. 73 (2) (a), requires that, "The licensee shall ensure that, no person simultaneously assists more than two residents who need total assistance with eating or drinking."

Inspector #542 observed on a home area during the meal service, one PSW serving food to the residents' while feeding other resident's their meal in between. The Inspector was informed by the RPN that the unit did not have a full complement of PSW staff.

Inspector #542 was approached by a family member for resident #014, who indicated that they were present in the home during a meal service and often observed the home short staffed and that the home did not have enough staff to feed the residents. They further indicated that food was left in front of the residents until there were staff available to assist them.

On a day during the inspection, Inspector #543 was observing the meal service on a home area and noted that they were short one PSW. Inspector #543 observed a PSW going back and forth between tables to feed the residents. The RN on the unit was assisting three residents at one table (a resident was moved to this table in order to have someone to feed them).

On a day during the inspection, Inspector #542 was observing on a home area in the dining room during the meal service. A dietary aide was observed providing the residents their fluids and indicated that they were running late and that they were trying to help the staff as they were working short.

RPN #144 indicated that they were required to move a resident from their assigned table to another table in the dining room where a staff member was present due to short staffing. [s. 73. (2) (a)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 5 th day of February, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by TIFFANY BOUCHER (543) - (A2)
Inspection No. / No de l'inspection :	2018_668543_0020 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	015358-18 (A2)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 05, 2019(A2)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Maple View of Sault Ste. Marie 650 Northern Avenue, SAULT STE. MARIE, ON, P6B-4J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marva Griffiths

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Extendicare (Canada) Inc., 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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols; and
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 229 (3); specifically,

The licensee shall seek, retain, and designate a staff member to coordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols; and
(e) outbreak management.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a designated staff member to co-ordinate the infection prevention and control program with education and experience in infection prevention and control practices including: a) infectious disease, b) cleaning and disinfection, c) data collection and trend analysis, d) reporting protocols and, e) outbreak management.

Two Critical Incident (CI) reports were submitted to the Director outlining two separate reportable outbreaks. The first report was submitted to the Director in January, 2018, indicating that there were three resident exhibiting signs and symptoms of an infection. The second CI report was submitted to the Director in April, 2018, indicating that seven residents were exhibiting signs and symptoms of an infection.

Inspector #542 reviewed the home's information regarding the above two outbreaks. Inspector #542 proceeded to interview the LTC Consultant #101 regarding the home's Infection Prevention and Control Lead (IPAC). They indicated that the home did not have a lead for the program with education and experience in infection prevention and control practices. The LTC Consultant #101 indicated that the current Director of Care and the Assistant Director of Care, along with themselves were sharing the role.

The severity of this issue was determined to be a level 1 as there was minimum risk. The scope of the issue was a level 3 as the issue affected all residents in the home. The home had a level 3 compliance history as they had 1 or more related non-compliance with this section of the legislation that included:

-Written Notification (WN) issued on August 2, 2017 (#2017_655679_0004).

(542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 18, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,

(a) has at least one year of experience working as a registered nurse in the long-term care sector;

(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and

(c) has demonstrated leadership and communication skills. O. Reg. 79/10, s. 213 (4).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 213 (4), specifically;

The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section, has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. 1. The licensee has failed to ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section, had at least three years of experience working as a registered nurse in a managerial or supervisory capacity in the health care setting.

During the course of the inspection, a concern was brought forward to Inspector #543, related to the qualifications and experience of the Director of Care hired in the home.

Inspector #543 reviewed a memorandum posted in the home, that indicated that DOC #102 was the home's new Director of Care; effective on a specific date in 2018.

Inspector #543 reviewed DOC #102's personnel file, which contained their Certificate of Registration with the College of Nurses of Ontario that identified a registration date from 2016.

Inspector #543 interviewed LTC Consultant #101 who verified that DOC #102 was registered with the College of Nurses of Ontario on a date in 2016.

Inspector #543 reviewed the requirements under the Long Term Care Homes Act, 2007 and the Ontario Regulations 79/10, with the LTC Consultant #101 who verified that they were not meeting the requirements and that it needed to be addressed.

The severity of the issue was determined to be a level 1 as there was minimal risk. The scope of the issue was a level 3, as it related to all residents in the home. The home had a level 2 compliance history with 1 or more unrelated non-compliance in the last 3 years.
(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 2019(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2018_616542_0009, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with O. Reg. 79.10, s. 31 (1).

The licensee shall prepare, submit and implement a plan to 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.

The plan must include the following:

-how the licensee will ensure that all residents are being provided a bath at a minimum of twice a week by their method of choice; and

-the residents' plan of care will identify the type of bath preferred, the day and time the residents' prefers their bath.

Please submit the written plan, quoting #2018_668543_0020 and Tiffany Boucher by email to SudburySAO.moh@ontario.ca. by November 7, 2018.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that each resident of the home was 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.

Inspector #542 conducted a Follow Up Inspection to Compliance Order (CO) #004 served to the licensee on June 19, 2018, under inspection report #2018_616542_0009. The CO required the home to be compliant with O. Reg 79/10, s. 33. (1) by July 30, 2018.

Inspector #542 reviewed the staffing assignment from a specific date in September, 2018, from a specific home area. According to the documentation, the home was short four PSW shifts on the evening shift. The unit had a regular home PSW and an agency PSW covering that unit.

A) A review of the bathing assignment from a specific home area, revealed that resident #037 and #038 were scheduled to have their bath/shower at a specific time and on a specific date in September, 2018.

Inspector #542 reviewed the Point of Care (POC) documentation for resident #037 and #038 and could not locate any information regarding the completion of their bath/shower from that specific date in September, 2018.

Inspector #542 completed a review of resident #037's care plan, located on PointClickCare (PCC); it was documented that they preferred to be bathed at a specific time of day and that they would be showered twice a week.

Inspector #542 reviewed resident #038's care plan which indicated that they preferred to have a bath at a specific time of day and that they would participate in bathing twice a week.

B) Inspector #542 completed a review of resident #042's POC charting from an evening shift on a specific date during the inspection and noted that PSW #149 had documented that the "activity did not occur." The progress notes did not contain any further information regarding resident #042's bath/shower.

Inspector #542 reviewed resident #042's care plan which indicated that they were to

receive a bath twice a week, at specific times.

C) Inspector #542 completed a review of the POC charting located on PCC for resident #043, it was documented under the bathing section, "not applicable."

Inspector #542 reviewed the progress notes located on PCC and was unable to locate any documentation to support why the bath/shower was "not applicable." The care plan for resident #043 identified that they preferred their bath at a specific time and on two specific days of the week.

Inspector #542 reviewed the home's staffing assignment from an evening shift on a specific date during the inspection and noted that the home was short five PSWs.

D) Inspector #542 reviewed the POC charting for resident #026 regarding bathing. It was documented that the "activity did not occur" and it was documented in the progress notes that staff were unable to complete resident #026's bath on a specific shift.

Inspector #542 reviewed the bathing assignment which indicated that resident #026 was to receive their bath/shower on a specific date during the inspection, at a specific time.

Inspector #542 reviewed resident #026's most recent care plan located on PCC and noted that they were to be bathed twice a week with the assistance from staff.

E) Inspector #542 completed a review of resident #044's care plan, which identified that they went to bed at a specific time of day.

Inspector #542 reviewed the 24 hour reports on PCC for each unit and located documentation that indicated that resident #044 and #045 had not received their scheduled baths/showers due to staff shortages and time restraints. The bathing assignment for the home area, identified that both residents were to have their shower/bath on a specific date, on a specific shift during the inspection.

Inspector #542 reviewed resident #044's care plan, which identified that they were to have a bath twice a week.

Inspector #542 reviewed resident #045's care plan, which identified that they were to be bathed twice a week, on specific days of the week.

Inspector #542 interviewed PSW #149, who worked on the dates the residents were to be bathed, and indicated that they were short staffed. PSW #149 indicated that the bath/shower for resident #042 was not completed as a result of being short staffed. They further indicated that resident #043 also did not receive their scheduled bath that shift.

Inspector #542 interviewed PSW #150 who indicated that on a day during the inspection, they worked short on the home area and that a bath/shower was not completed for resident #026.

Inspector #542 interviewed RPN #134 who was working on a day in September, 2018, on a specific home area, during a specific shift. RPN #134 indicated that they did not have a full complement of PSWs and did not believe that they were able to complete all of the assigned baths/showers.

RN #125 informed Inspector #542 and #543 that the home was short staffed on the previous evening shift. RN #125 indicated that they did not believe that the staff were able to complete the baths/showers for the residents during that shift.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was a level 3 as it affects a large number of residents. The home had a level 4 compliance history as they had on-going non-compliance with this section of the LTCHA that included:

-compliance order (CO) issued January 16, 2018 (#2017_616542_0018);
-CO issued on June 7, 2018 (#2018_616542_0009)
(542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2018

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2018_616542_0009, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79.10, s. 31 (1).

The licensee shall prepare, submit and implement a plan to ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents.

The plan must include, but is not limited, to the following:

-how the licensee will review and revise staffing patterns for each unit in the home; related to the needs of all residents;

-how the licensee will recruit and retain staff who provide nursing and personal support services in order to meet the needs of the residents;

-a back-up plan for nursing and personal care staffing, to address situations when staffing levels are short;

-how the licensee will promote continuity of care, by minimizing the number of different staff members who provide nursing and personal support services to each resident; and

Please submit the written plan, quoting #2018_668543_0020 and Tiffany Boucher by email to SudburySAO.moh@ontario.ca. by November 7, 2018.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Inspector #542 conducted a Follow Up inspection to Compliance Order (CO) #003 served to the licensee on June 19, 2018, under inspection report #2018_616542_0009. The CO required the home to be compliant with O. Reg 79/10, s. 31 (1) by July 30, 2018. In addition, several complaints were received by the Director, from family, and residents during the course of the inspection. The

complainants outlined concerns related to the shortage of staff and how it was affecting the care of residents in the home.

A) Documentation review:

Inspector #542 requested that the scheduling and payroll departments provide documents that identified when the home did not have a full complement of PSWs from August, 2018, to September, 2018. Together, Inspector #542 and the Director of Care (DOC) reviewed the documentation, they confirmed where the home was without a full complement of staff; the following was verified:

During the month of August 2018, the home failed to meet their planned staffing contingency on 27 out 31 days, or 87 percent of the days in the month. The staffing deficiency in the month of August, 2018, totaled 183 missed PSW shifts, with an average of seven PSW vacancies per day. In the month of September, 2018, the home failed to meet their planned staffing contingency on 24 out of 30 days, or 80 per cent of the days in the month. The staffing deficiency in the month of September, 2018, totaled 147 missed PSW shifts, with an average of five PSW vacancies per day.

Inspector #542 interviewed Labour Relations Officer #154 and RN #155. Labour Relations Officer #154 indicated that the RNs were not receiving the resources required to complete resident care. They indicated that the home had been short staffed, causing the RN's to complete medication administration for the residents when they were unfamiliar with this role as the home typically had the RPNs completing that duty. They indicated that RNs had been completing "Professional Responsibility Workload" forms that indicated that the home had been short-staffed. The completed forms indicated that on occasion, the RNs were unable to complete wound dressings and other RN duties, staff were unable to provide care to the residents safely, and the home had agency staff working on units alone where they were not familiar with the residents.

Inspector #542 interviewed union representative #156 who represented PSWs and the RPNs in the home. They provided a copy of the completed, "Workload Review" forms filed to the home from the PSWs, RPNs and housekeeping staff. Inspector #542 completed a review of the completed forms and found, 54 forms were completed during August and September, 2018, outlining that the home was short

staffed. A further review of the completed forms identified that at times, PSWs were working alone on a unit, were unable to provide continence care for residents that required two staff members, described unsafe working conditions, were unable to provide proper care to the residents, were unable to answer call bells and alarms in a timely fashion, and described that residents were being rushed.

Inspector #542 was provided with a document from the Office Manager, dated September 6, 2018, which indicated that the home had numerous PSW positions that remained unfilled. Inspector #542 verified this information with the DOC. Furthermore, there were several RPN position that remained unfilled.

B) Bathing:

O. Reg. 79/10, s. 33 (1), requires that, "Every licensee of a long-term care home 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."

Inspector #542 reviewed the staffing assignment from a date in September, 2018, from a specific home area that was provided by the payroll department. According to the documentation, the home was short four PSW shifts during a specific shift.

A review of the bathing assignment from a home area, revealed that scheduled baths or showers were not provided during a specific shift, as a result of being short staffed. RN #125 informed Inspector #542 and #543 that the home was short staffed on the previous evening shift. RN #125 indicated that staff were unable to complete the baths/showers for the residents on that shift. Two days later, Inspector #542 reviewed the 24 hour reports on PCC for each unit and located documentation that indicated that resident #044 and #045 did not receive their scheduled baths/showers due to staff shortages and time restraints. The bathing assignment for the home area, identified that both residents were to have their shower/bath during the specific shift. See WN #3 for further detail.

C) Feeding:

O. Reg. 79/10, s. 73 (2) (a), requires that, "The licensee shall ensure that, no person simultaneously assists more than two residents who need total assistance with

eating or drinking."

On a day during the inspection, Inspector #542 observed a home area during a meal service. Inspector #542 observed one PSW serving food to the residents' while feeding other resident's their meal in between. The Inspector was informed by the RPN that the unit did not have a full complement of PSW staff.

On a different day during the inspection, Inspector #543 was observing a meal service on a home area and noted that they were short one PSW shift. Inspector #543 observed a PSW going back and forth between tables to feed the residents. The RN on the unit was assisting three residents at one table (a resident was moved to this table in order to have someone to feed them).

On the same day as Inspector #543, Inspector #542 observed a different home area during the meal service. A dietary aide was observed providing the residents their fluids and indicated that they were running late and that they were trying to help the staff as they were working short. RPN #144 indicated that they were required to move a resident from their assigned table to another table in the dining room where a staff member was present due to short staffing.

D) Plan of care:

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

On a day during the inspection, Inspector #542 and #543 observed on a specific home area that was short staffed. The Inspectors observed resident #044 up in the common area without pants, sitting directly across a co-resident. PSW #151 indicated that the resident was due to be bathed on that day, they were short staffed and that was why they were not wearing pants. Inspector #542 completed a review of resident #044's care plan, which identified that they went to bed at a specific time (one and half hours earlier than when the resident was observed). See WN #5, -5 for further detail.

Inspector #542 and #543 proceeded to another home area and found seven residents still up in the common area. Residents were observed sleeping. A PSW came and indicated that resident #046 was going to be taken for their bath. Resident

#046's care plan indicated that they preferred to go to bed at a specific time (between one and half to two hours before the resident was observed), but was still up. Resident #047 was observed falling asleep. Inspector #542 reviewed resident #047's care plan which identified that they preferred to be transferred to bed at a specific time (between two to three hours before the resident was observed). Resident #013 was also observed up in the common area, a review of their care plan indicated that they went to bed at a certain time (between one and a half and two and half hours before the resident was observed). See WN #5, -5 for further detail.

Inspector #542 interviewed RPN #144, who was working on a specific home area. RPN #144 indicated that the home area was short staffed and typically the residents would all be in bed at that time.

On a date during the inspection, resident #041 sustained a fall that resulted in injuries. Inspectors #543 and #542 interviewed the DOC and the ADOC who indicated that resident #041 required a specific frequency of monitoring and that did not occur at the time of the fall. See WN #5, -4 for further detail.

E) Nursing and Personal Support Services:

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

Inspector #542 and Inspector #543 were observing a home area. Resident #032 approached the Inspectors and indicated that they wished to speak to the Inspectors. Resident #032 indicated that they were experiencing pain to a certain area of their body as they were left for too long and that they frequently had to wait a long time for assistance. Resident #032 identified that staff typically assisted them around a preferred time as this was when the staff asked the resident and if the resident refused at that time, then they would have to wait until much later. They also indicated that the home was frequently short staffed and that they did not know how much more they could take. Resident #032 indicated that often after one meal they were placed in a common area until around the next meal. Before that next meal, resident #032 would request assistance with an activity of daily living; however, staff would tell them that they would have to wait as they did not have the time to transfer

them back before the meal service.

On a specific date during the inspection, Inspector #542 observed resident #034 requiring assistance. Inspector #542 observed that the home area was short staffed as a PSW was transferred to another unit where they were also short staffed. Inspector #542 observed staff enter resident #034's room, 30 minutes later.

Inspector #543 interviewed PSW #145 who indicated that on the date resident #034 was observed requiring assistance, the PSWs were not able to complete their last rounds as a result of having to complete their charting. They indicated that it was a result of not having adequate staff scheduled for that shift.

F) Duty to Protect:

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

O. Reg. 79/10 defines neglect as "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 jeopardized the health, safety or well-being of one or more residents."

Inspector #542 reviewed the home's staffing plan specific to the previous shift, and noted that the home was short four PSWs.

Inspector #542 interviewed the PSW staff who came on shift after the home was short staffed on the previous shift, from a specific home area. PSW #141, #157 and #158, indicated that numerous residents were found incontinent with soiled bedding; as well, some residents that were to wear incontinent products, had nothing on. One resident had altered skin integrity as a result of being incontinent. Another resident was still dressed in clothing from two shifts previous which was soiled, along with their bedding.

Inspector #542 interviewed PSW #149, who worked that specific shift, on a certain home area. PSW #149 indicated that no other PSWs were working on that unit as they were short staffed. They identified that they were unable to provide care for

multiple residents for the whole eight hour shift, as a result of short staffing.

Inspector #542 reviewed the CI report that was submitted to the Director, outlining staff to resident neglect. The report indicated that multiple residents had not received care during a shift, as the PSW was working alone due to short staffing. See WN #6 for further detail.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 3 as the issue affected all residents in the home. The home had a level 4 compliance history as they had on-going non-compliance with this section of the LTCHA that included:

-CO issued on June 7, 2018 (#2018_616542_0009); and
-CO issued on January 23, 2018, (#2017_616542_0018).

(542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2018

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2018_616542_0009, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s 6 (7).

The licensee shall prepare, submit and implement a plan to ensure compliance with LTCHA, 2007, s 6 (7).

The plan shall include, but is not limited to, the following:

-a comprehensive description that identifies, how the licensee will ensure that care set out in the residents' plan of care is provided to residents' #002, #022, #033, #034, #039, #041, #044, #046 and #047 as specified in their plan; specifically related, but not limited to; bathing, responsive behaviours, feeding, and any other assessed needs of the residents.

Please submit the written plan, quoting #2018_668543_0020 and Tiffany Boucher by email to SudburySAO.moh@ontario.ca. by November 7, 2018.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

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

Inspectors conducted a Follow Up inspection to Compliance Order (CO) #001,

served to the licensee on June 7, 2018, under inspection report #2018_616542_0009. The CO required the licensee to ensure they were compliant with LTCHA, 2007 S.O. 2007, c.8, s. 6 (7) by July 30, 2018.

A complaint was submitted to the Director regarding care concerns of resident #022. The complaint identified that the resident had a fallen on a date in November, 2017, which the family was not made aware of and that care was not being implemented properly.

Inspector #638 reviewed resident #022's health care records and identified a progress note created, by RPN #104 which indicated that the resident was found by a PSW to be seated in an unsafe manner. The PSW was unable to reposition the resident and had to manually lower the resident to the floor and lift them using a mechanical lift. The PSW reported to the RPN that the resident's interventions were not implemented at the time of the incident. The resident was assessed and noted to have an injury.

Inspector #638 reviewed resident #022's care plan and identified in the care plan in effect at the time of the incident the resident was to have specific interventions implemented to alert staff and prevent falls. The Inspector reviewed the resident's "PSW documentation in Daily Care Flow sheet supports MDS 2.0 Coding" and identified the record had no documentation from the day the resident fell, identifying that the resident's specific interventions were implemented.

In an interview with Inspector #638, PSW #110 indicated that in 2017, direct care staff used paper documentation to identify the care and interventions implemented for a resident. The PSW stated that if a resident had a specific intervention that they would document the intervention. Upon reviewing resident #022's, "PSW documentation in Daily Care Flow sheet supports MDS 2.0 Coding" record, from specific dates between October and November, 2017, the PSW indicated that if the resident required an intervention, direct care staff were to ensure that it was implemented and document the care provided.

During an interview with Inspector #638, RPN #104 indicated that they were working at the time of the incident. The RPN stated the PSW found the resident seated in an unsafe manner. The RPN was unable to recall the specific interventions the resident required, but indicated that the resident was at a specific risk for falling and believed

they had an intervention that was supposed to be implemented.

Inspector #638 interviewed RPN #109 who indicated that PSWs were responsible for implementing and documenting interventions as identified within the resident's care plan. The RPN stated that the home previously used a paper record for documenting care and direct care staff had to ensure that the interventions in the care plan were implemented and documented. The RPN indicated that staff were required to follow the tasks and interventions laid out within the resident's care plan.

The home's policy titled "Care Planning – RC-05-01-01" last updated April 2017, indicated that "a care plan is a guide that directs care that is provided to the resident. Individual resident care plans reflect specific information about a resident including identification of individual problems and their expected outcomes, interventions required to produce expected outcomes, and clinical care requirements with proposed time limits for implementation".

In an interview with Inspector #638, the DOC and ADOC stated that staff referred to a resident's care plan and kardex for specific interventions. The DOC indicated that care was supposed to be provided as outlined within the plan. The Inspector reviewed resident #022's, progress note with the DOC and ADOC. When asked if they would have expected staff to implement the interventions as laid out within the care plan, they stated "absolutely" and if not they would have expected documentation to support why the interventions were not implemented. [s. 6. (7)]

2. Resident #002 was identified during the inspection as having impaired skin integrity.

Inspector #542 reviewed resident #002's health care record, related to their impaired skin integrity. Inspector #542 reviewed the weekly wound assessments which indicated that resident #002 had impaired skin integrity to several parts of their body. A review of the current care located on PCC, under the focus heading, "Altered Skin Integrity" it was documented that resident #002 was to have specific devices applied.

On two separate dates, Inspector #542 observed resident #002 in their room, without the specific devices applied.

Inspector #542 interviewed RPN #140 who indicated that resident #002 had impaired skin integrity. RPN #140 indicated that resident #002 frequently had areas of altered skin integrity and that one of the interventions was to ensure that they had a specific device applied at all times. [s. 6. (7)]

3. A complaint was submitted to the Director regarding an incident which occurred on a date July, 2018, where resident #039 was cared for in an improper manner.

Inspector #638 reviewed PSW #147's "Discipline Notice", related to the incident. The notice identified that while assisting resident #039, the PSW did not provide care according to the resident care plan. The notice identified that it was required that staff check the care plan before providing care.

The Inspector reviewed resident #039's care plan and identified that the resident was supposed to be transferred using a specific assistive device at all times. The care plan also identified that the resident was supposed to be toileted in a specific manner.

In an interview with Inspector #638, PSW #147 indicated that they were working on another unit but noticed the call bell had been sounding for about 20 minutes. The PSW indicated they responded to the resident's bell and assisted the resident. The PSW stated they used to work extensively with resident #039 and they were not aware that the interventions in their care plan had changed. The PSW acknowledged, they did not check the care plan prior to providing care.

In an interview with Inspector #638, the DOC and ADOC stated that staff referred to a resident's care plan and kardex for specific interventions. The DOC indicated that resident care was supposed to be provided as outlined within the resident's plan. [s. 6. (7)]

4. During the inspection two separate incidents of resident #041's Responsive Behaviours were brought forward. On a date in September, 2018, resident #041 was agitated, and was sitting with RPN #119, when they displayed responsive behaviours towards the staff member. Two days later, resident #041 sustained a fall, that resulted in several injuries.

Inspector #543 reviewed this resident's care plan, specifically related to responsive

behaviours which identified that the resident was to be provided with a specific frequency of monitoring.

Inspector #543 reviewed resident #041's progress notes, which had a late entry documented, identifying that the resident had fallen and sustained injuries.

The Inspector reviewed the home's Nursing Department Daily staffing sheet, which identified that the unit the resident resided on did not have monitoring scheduled for this resident.

The Inspector interviewed PSW #152 who verified that the resident was started on specific frequency of monitoring, but indicated there was no consistency with the monitoring, and there were times when the monitoring was not provided.

The Inspector interviewed RPN #119 who verified that the home was short staffed that evening, and that the monitoring for this resident was not available and was not replaced.

Inspector #543 interviewed RPN #153 who verified that resident #041 required specific frequency of monitoring; however, there had not been any consistency with providing the monitoring, as a result of the home being chronically understaffed. The RPN indicated that the resident had a fall, two days after the responsive behaviour incident, at the time of the fall there was no specific frequency of monitoring provided for the resident.

Inspector #543 interviewed RN #125 who verified that on the day the resident fell, the resident was supposed to be provided with a specific frequency of monitoring but was not.

Inspectors #543 and #542 interviewed the DOC and the ADOC. They indicated, that resident #041 was found on the floor after falling. The verified that there was no monitoring present at the time of the resident's fall. [s. 6. (7)]

5. a) On September 20, 2018, Inspector #542 observed resident #034 attempting to stand up. Resident #034 was observed to have a safety device that was improperly applied, rendering the device inoperable. Another safety device was also observed on; however, it was not correctly applied. Inspector #542 observed resident #034 for

more than 20 minutes and observed a staff member walk past the resident.

Inspector #542 reviewed the current plan of care located in the binder on the unit. Under the focus heading "Risk for Falls", it was documented that resident #034 was to have a specific safety devices applied to alert the staff and prevent falls.

Inspector #542 interviewed PSW #143, who indicated that resident #034 was to have safety devices.

b) Inspector #542 and Inspector #543 were observing on a home area. Inspector #542 observed resident #033 in the common area in a chair that was not positioned properly, no foot rests were on the chair and the resident's feet were bare. Resident #033 was observed attempting to sit up in their chair and trying to move the chair on numerous occasions, however was unable to do so, as the chair was not positioned properly.

Inspector #542 reviewed resident #033's most recent care plan. Under the foci, "Falls", it was documented that resident #033 was to have a safety device applied and that staff were to ensure that they had specific type of socks on.

Inspector #542 interviewed PSW #143, who indicated that resident #033 was to be positioned a certain way when they were displaying specific responsive behaviours. They indicated that staff would position the resident's chair back and then put their feet up on a chair and that they were to have specific type of socks on.

c) Inspector #542 and #543 observed on a specific home area that was short staffed. The Inspectors observed resident #044 up in the common area without pants, sitting directly across a co-resident. PSW #151 indicated that the resident was due to be bathed on that day, they were short staffed and that was why they were not wearing pants.

Inspector #542 completed a review of resident #044's care plan, which identified that they required special interventions related to an activity of daily living. It was documented in resident #044's care plan, that they went to bed at a specific time (one and half hours earlier than when the resident was observed).

Inspector #542 and #543 observed a home area, and identified multiple residents in

the common area, some of them were asleep. A PSW came and indicated that resident #046 was going to have their bath now.

Inspector #542 reviewed resident #046's care plan, which indicated that the resident's had a preferred bed time.

Resident #047 was observed in the common area, falling asleep.

Inspector #542 reviewed resident #047's care plan which identified that they liked to be transferred to bed at a specific time.

Resident #013 was also observed up in the common area, a review of their care plan indicated that the resident's preferred bed time was at a certain time.

Inspector #542 interviewed RPN #144, who was working on the home area who indicated that the home area was short-staffed and typically the resident's would all be in bed at that time.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 2 as the issue was determined to be a pattern. The home had a level 4 compliance history as they had on-going non-compliance with this section of the LTCHA that included:

-CO issued on October 5, 2016 (#2016_395613_0013);
-CO issued on February 27, 2017 (#2016_562620_0030);
-written notification (WN) issued on May 10, 2017 (#2017_572627_0005);
-Director referral (DR) issued on August 10, 2017 (#2017_655679_0004);
-DR issued on January 16, 2018 (#2017_616542_0020); and
-DR issued on June 19, 2018 (#2018_616542_0009).

(638)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 006

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

Linked to Existing Order / Lien vers ordre existant: 2018_616542_0010, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with LTCHA 2007, s. 19 (1).

The licensee shall prepare, submit and implement a plan in order to be in compliance with LTCHA 2007, s. 19 (1). The plan shall include but is not limited, to the following:

-how the licensee will ensure that all residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff;

-how the licensee will ensure that when any resident has a serious injury or serious illness, the resident's substitute decision maker will be notified; and

-how the licensee will ensure that care provided to residents in the home, is provided in a manner that is consistent with their specific care needs.

Please submit the written plan, quoting #2018_668543_0020 and Tiffany Boucher by email to SudburySAO.moh@ontario.ca. by November 7, 2018.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were protected from abuse by

anyone and failed to ensure that resident were not neglected by the licensee or staff.

Inspector #542 conducted a Follow Up inspection to Compliance Order (CO) #001, served to the licensee on June 7, 2018, under inspection report #2018_616542_0010. The CO required the licensee to ensure they were compliant with LTCHA, 2007 S.O. 2007, c.8, s. 19 (1) by July 6, 2018.

O. Reg. 79/10 defines neglect as "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 jeopardized the health, safety or well-being of one or more residents."

A) O. Reg. 79/10, s. 31 (1), requires that, "The licensee ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents".

Inspector #542 reviewed the home's staffing plan for a specific shift, and noted that the home was short several PSWs.

Inspector #542 interviewed the PSW staff who came on shift after the home was short staffed that specific shift. PSW #141, #157 and #158, indicated that numerous residents were found incontinent with soiled bedding; as well, some residents that were to wear incontinent products, had nothing on. One resident had altered skin integrity as a result of being incontinent. Another resident was still dressed in clothing from two shifts previous which was soiled, along with their bedding.

Inspector #542 interviewed PSW #149, who worked that specific shift who indicated that no other PSWs were working on that unit as they were short staffed. They identified that they were unable to provide care for multiple residents for the whole eight hour shift, as a result of short staffing.

Inspector #542 reviewed the Critical Incident (CI) report that was submitted to the Director by the licensee, outlining staff to resident neglect. The report indicated that multiple residents did not receive care on a specific shift in September, 2018, as the PSW was working alone due to short staffing. See WN #4 for further detail.

Inspector #542 interviewed the DOC, who indicated that RN #155 and PSW #149

were both disciplined as a result of the neglect of multiple residents.

B) Inspector #542 and #543 were approached by resident #035's family member. They indicated that resident #035 previously resided in the home, however had passed away.

Inspector #542 completed a review of resident #035's health care record. Upon resident #035's admission to the home, it was documented on the physician's orders; that resident #035 had specific Health Care Directives, which identified being transferred to an acute care hospital for treatment.

Inspector #542 reviewed the progress notes located on PCC, which identified the following related to resident #035's health condition over a 12 hour period:

- resident #035 indicated that they were not feeling well. The resident was later found incontinent and refused a meal. A family member asked for a specific medical intervention.

- resident was assisted by their family member as the resident became weak. Vital signs were taken with some abnormal results. Registered Nurse was made aware of the resident's condition. Noted in the Medical Director's book.

- New set of vitals taken and recorded, some abnormal results.

- PSW indicated that the resident was incontinent, noted in calendar to initiate a diagnostic medical intervention later as the resident was too unwell.

- PSW reported that the resident did not appear well. Writer went to check and resident did not look well at all. Called ambulance.

- Writer on way back to resident's room, resident had passed away. No pulse present. Called ambulance and told them no need for them to come anymore.

- Notified POA of the resident's passing.

Inspector #542 reviewed the "on-call" physician's documentation which indicated that they were called regarding an "unexpected death." The physician also documented

that no physician was contacted regarding resident #035's illness.

Inspector #542 and #543 were approached by resident #035's family who indicated that they felt that had they been notified of the resident's change in condition, perhaps that could have changed the outcome. The family was very upset, and met with the home's management team, who verified that staff should have informed the family, specifically the resident's substitute decision-maker, of the resident's change in condition. The management team informed the family the RN would no longer be working in the home.

Inspector #542 interviewed the DOC, asked if they felt that the death of resident #035 was unexpected. The DOC indicated that the death was unexpected. The Inspector asked if any of the registered staff had notified the physician of the resident's change in condition prior to their death. According to the documentation, some of the resident's vitals were abnormal. The DOC verified that nobody had notified the physician.

In a subsequent interview with the DOC, Inspector #542 asked them if any of the staff members notified the family of resident #035 when their health status changed the day prior to their death. The DOC indicated that nobody had contacted the family prior to their death and that they spoke with all of the staff involved, specifically the RN that was working the shift when resident #035 passed away. Inspector #542 asked the DOC if any of the staff notified the physician when resident #035's condition had changed. The DOC verified that the staff notified the physician after the resident had passed away. The DOC indicated that a RN was working on the unit, in the capacity of the RPN on the unit as a result of short staffing, and that the RN would no longer be working in the home. See WN #10 for further detail.

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

i) Resident #041 sustained a fall that resulted in injuries.

Inspector #543 reviewed resident #041's progress notes, which indicated a late entry documented, identifying that the resident had fallen and sustained injuries.

The Inspector reviewed the home's Nursing Department Daily staffing sheet for the

date on which the resident fell, which identified that the unit the resident resided on did not have a specific frequency of monitoring scheduled for this resident.

Inspectors #543 and #542 interviewed the DOC and the ADOC. They indicated, that resident #041 was found after falling. They verified that there was no monitoring present at the time of the resident's fall.

ii) On a date in September, 2018, Inspector #542 and #543 observed on a home area, that several residents remained up in the common area of the unit. The Inspectors identified that residents neglected to have their care provided as specified in their plan of care.

Inspector #542 interviewed RPN #144, who was working on that home area, who indicated that the home area was short-staffed and typically the resident's would all be in bed at that time. See WN #5 for further detail.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 2 as the issue was determined to be a pattern. The home had a level 4 compliance history as they had on-going non-compliance with this section of the LTCHA that included:

-CO issued on August 14, 2016 (#2016_395613_0007);
-CO issued on February 27, 2017 (#2016_562620_0030); and
-CO issued on June 7, 2018 (# 2018_616542_0010);
(542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 23, 2018

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 007

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

Linked to Existing Order / Lien vers ordre existant: 2018_616542_0009, CO #002;

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).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, s. 20 (1).

The licensee will retrain PSW #147 and all other staff specifically related to the home's, "Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-01".

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #638 conducted a Follow Up inspection to Compliance Order (CO) #002, served to the licensee on June 19, 2018, under inspection report #2018_616542_0009. The CO required the licensee to ensure they were compliant with LTCHA, 2007 S.O. 2007, c.8, s. 20 (1) by July 30, 2018.

A complaint was submitted to the Director regarding an incident which occurred on a date in July, 2018, where resident #039 was cared for in an improper manner.

Verbal abuse is defined within the Ontario Regulation 79/10, as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's

sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Inspector #542, Inspector #543 and Inspector #638 each observed a video recording of resident #039 and PSW #147 responded to the resident's question in a verbally inappropriate manner.

Inspector #638 reviewed PSW #147's "Discipline Notice", related to the incident. The notice identified that while assisting a resident with care, the PSW spoke to resident #039 in a verbally inappropriate manner.

The Inspector reviewed resident #039's health care records and identified in their care plan under the "Mood" foci that the resident required specific interventions related to verbal communication.

In an interview with Inspector #638, PSW #147 indicated that they were working on another unit but noticed the call bell had been sounding for about 20 minutes. The PSW indicated they responded to the resident and stated that their approach was inappropriate

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-01" last updated April 2017, identified verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident. The policy identified examples of verbal abuse as inappropriate tone of voice, abusive language, yelling, swearing, rude, offensive or sexual comments or gestures.

In an interview with Inspector #638, the DOC and ADOC indicated that PSW #147's actions towards resident #039 were not appropriate and that during this incident the PSW was not following the home's policy to promote zero tolerance of abuse.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was a level 1 as the issue was related to one incident. The home had a level 4 compliance history as they had on-going non-compliance with this section of the LTCHA that included:

-Voluntary Plan of Correction (VPC) was issued on August 14, 2016 (#2016_395613_0007);
-VPC issued on October 5, 2016 (#2016_395613_0014);
-CO was issued on February 24, 2017 (#2016_562620_0029);
-CO was issued on August 2, 2017 (#2017_665679_0004);
-CO was issued on December 22, 2017 (#2017_616542_0020); and
-CO was issued on June 7, 2018 (#2018_616542_0009).

(638)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 18, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 107 (5), specifically;

The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident's substitute decision maker, if any , or any person designated by the substitute decision-maker and any other person designated by the resident were promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be notified.

Inspector #542 and #543 were approached by resident #035's family member regarding concerns related to the resident's death. The resident's family indicated that the resident passed away unexpectedly, and that the family was not notified until the staff found the resident deceased. The family had concerns related to the resident's abnormal vital signs prior to their death. The family felt that if they had been notified of the resident's change in condition, perhaps that could have changed the outcome. The family was very upset, and met with the home's management

team, who verified that staff should have informed the family, specifically the resident's substitute decision-maker, of the resident's change in condition. The management team informed the family the RN would no longer be working in the home.

Inspector #542 completed a health care record review for resident #035. It was documented, that resident #035 did not feel well; they refused meals. The family requested that the home initiate a medical diagnostic intervention. An assessment was completed by a nurse, which indicated that the resident had an abnormal vital sign reading prior to their death. Later, another assessment was completed which showed that resident #035's vital signs were abnormal. The RN called the family and notified them that resident #035 had passed away.

Inspector #542 interviewed the DOC, asked if they felt that the death of resident #035 was unexpected. The DOC indicated that the death was unexpected. The Inspector asked if any of the registered staff had notified the physician of the resident's change in condition prior to their death. According to the documentation, the resident's vital signs were abnormal. The DOC verified that nobody had notified the physician. Inspector #542 then asked if anyone had notified the family about the resident's status, to which the DOC verified that the family was only notified after the resident died. The DOC indicated that they should have notified the family sooner when they charted the resident's change in condition, at the very least, they should have notified the family when they assessed resident #035's vital signs to be abnormal.

The severity of this issue was determined to a level 3 as there was actual harm. The scope of the issue was a level 1 as it was related to one incident. The home had a level 3 compliance history as they had 1 or more related non-compliance with this section of legislation that included:

-written notification (WN) issued on December 22, 2017 (#2017_616542_0019); and
-WN issued on June 7, 2018 (#2018_616542_0011). (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 23, 2018

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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, 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:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et 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 5 th day of February, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by TIFFANY BOUCHER (543) - (A2)

Ontario

Ministry of Health and Long-Term Care

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