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

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Original Public Report

Report Issue Date September 29, 2022
Inspection Number 2022_1504_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other

Licensee
Ritz Lutheran Villa

Long-Term Care Home and City
Ritz Lutheran Villa, Mitchell

Lead Inspector
Julie Lampman #522

Additional Inspector(s)
Samantha Perry #740
Loma Puckerin #705241

Inspector Digital Signature
Julie Lampman
Digitally signed by Julie Lampman
Date: 2022.10.18 08:35:02 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 21, 22, 25, 26, 27, 28, August 2, 3, 4, 5, 8, 9, 2022, on site August 10, 11, 2022, off site.

The following intake(s) were inspected:

- Intake #006428-22 (CIS: 3007-000007-22/3007-000008-22) related to falls prevention and management
- Intake # 013146-22 (CI: 3007-000021-22) related to responsive behaviours
- Intake # 013208-22 (CI: 3007-000022-22) related to responsive behaviours
- Intake # 014479-22 (Complaint) related to falls, medication management, plan of care, isolation protocols
- Intake # 012533-22 (Complaint) related to reporting, abuse & neglect, care planning and documentation
- Intake # 009140-22 (Complaint) related to abuse & neglect

The following **Inspection Protocols** were used during this inspection:

- Continence Care
- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Resident Care and Support Services

- Responsive Behaviours
- Skin and Wound Prevention and Management

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

NON-COMPLIANCE REMEDIED #001

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of residents and on the needs and preferences of those residents.

Review of two residents' care plans noted no preferences related to bathing.

The Director of Care (DOC) reviewed the residents' care plans with Inspector #522 and acknowledged there were no bathing preferences included in the residents' plans of care.

The DOC stated they had followed up with staff to ensure bathing preferences were in the residents' care plans.

Review of both residents' care plans noted they had been updated with their bathing preferences.

Sources: Review of two residents' care plans and interview with the DOC.

Date Remedy Implemented: August 11, 2022 [522]

WRITTEN NOTIFICATION - PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (9) 1

The licensee has failed to ensure that resident baths were documented.

Rationale and Summary

The Ministry of Long-Term Care received an anonymous complaint that residents in the home were not receiving their baths.

Review of two residents' Documentation Survey Reports noted no documentation that a bath was given or refused on a specific date.

Review of another resident's Documentation Survey Report noted no documentation that a bath was given or refused on six occasions over the course of a month.

The Director of Care (DOC) acknowledged the missing documentation. The DOC stated that during the home's current outbreak staff reported they did not have time to document.

Sources:
Observations of residents' care, review of three residents' clinical records and interviews with the DOC and other staff.

[522]

WRITTEN NOTIFICATION - COMPLAINTS PROCEDURE LICENSEE

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 26 (1) (c)

The licensee has failed to ensure that any written complaint that it received concerning the care of a resident or the operation of a long-term care home was immediately forwarded to the Director in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to concerns that were submitted to the home via an e-mail. A copy of the e-mail which outlined several concerns related to a resident's care was also forwarded to the MLTC by the complainant. The complainant indicated the home's response to the expressed concerns to be "dismissive" and that they felt their concerns had not been resolved.

The resident's progress notes indicated there had been ongoing communication related to the resident's care between the complainant and the home's staff.

During an interview, the Director of Care (DOC) acknowledged that an e-mail with resident care concerns had been received by the home and it was not submitted to the Director.

The Administrator agreed that the e-mail with the concerns related to the care of the resident was received by the home. The Administrator stated the e-mail was not considered to be a

formal complaint because the complainant did not say they wanted an investigation. Therefore, concerns in the e-mail did not warrant submission to the Director.

Sources: Complaint to the MLTC, the resident's progress notes, review of the home's Complaints Binder, interviews with the complainant, the DOC and the Administrator.

[705241]

WRITTEN NOTIFICATION - LICENSEE MUST INVESTIGATE RESPOND AND ACT

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 27(1) (a) (i)

The licensee has failed to ensure every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knew of, or that was reported to the licensee, was immediately investigated.

Rationale and Summary

A) The Ministry of Long-Term Care received a complaint concerning allegations of staff to resident abuse.

The home's policy related to zero tolerance of abuse and neglect stated, Ritz Lutheran Villa would implement a comprehensive zero tolerance program including measures to promptly and thoroughly investigate all alleged or reported incidents in a fair and transparent manner. The Administrator, Designate or Department Manager Supervisor would promptly and thoroughly investigate all alleged, suspected or witnessed incidents of abuse or neglect. Upon completion, immediately report the results of all investigations to the resident's Substitute Decision Maker (SDM) or designate.

Review of the home's notes documented, a staff member reported concerns of alleged staff to resident abuse to another staff member. That staff member emailed the Director of Care (DOC) a summary of the alleged incident and requested the incident be followed up. The DOC replied to the staff member's email and said the incident would be followed up by the DOC and Assistant Director of Care (ADOC). However, the staff member who reported the abuse and the accused staff member were not interviewed by the DOC until eleven days after the alleged incident, and the accused staff member was not removed from the home, to mitigate any risk, pending the home's investigation. The alleged incident of staff to resident abuse was not immediately investigated as per the home's policy or as legislated.

In an interview, the Administrator and the Director of Care (DOC) both said the home did not immediately investigate the allegation of staff to resident abuse as per their policy or as legislated and should have.

There was moderate impact and risk to the resident when the alleged incident of staff to resident abuse was not immediately investigated.

Sources: The home's abuse and neglect policy, a staff members employee file and interviews with staff and management.
[740]

B) Review of documentation regarding an investigation involving a staff member noted progress notes related to an incident with a specific resident.

The progress notes indicated that there had been a verbal altercation between the staff member and the resident. The resident reported to another staff member that the staff member they had the verbal altercation with, acted like they were the boss and stated that as a resident they deserved respect.

The progress note indicated that the incident would be reported to the oncoming shift and the Director of Care (DOC).

The DOC stated that they had received an email about the incident between the staff member and the resident, seven days after the incident. The DOC stated the incident should have been reported to the oncall manager immediately as the person should have been put on an administrative leave and the incident investigated. The DOC acknowledged that they had not spoken to the staff member until 13 days after the incident occurred.

Sources:

Review of the resident's clinical record, documentation related to a staff member, and interview with the DOC.

[522]

WRITTEN NOTIFICATION - REPORTING TO THE DIRECTOR

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 28 (1) 1

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

Rationale and Summary

The Ministry of Long-Term Care received an anonymous complaint related to the unsafe provision of care to residents.

A staff member stated that staff had reported to them that another staff member was providing care to residents in an unsafe manner. The staff member stated they reported this to the staff member in charge and emailed the Assistant Director of Care (ADOC) who was offsite and the Director of Care (DOC) who was off. The staff member stated they had received an anonymous written complaint letter regarding the staff member providing care to residents in an unsafe manner.

The Assistant Director of Care (ADOC) acknowledged that they had received the anonymous written complaint when they returned to the home and had received the email the day prior to returning to the home.

The ADOC acknowledged that there was risk of harm to residents as the staff member was providing care to residents in an unsafe manner. The ADOC stated they had not submitted a Critical Incident System (CIS) report to the Director as they were not aware they were required to submit a CIS report for improper care of a resident that caused risk of harm to the resident.

The Administrator acknowledged a CIS report had not been submitted and stated they would only submit a CIS report to the Director if there was actual harm to a resident.

Sources:
Review of a written complaint to the home, email correspondence, the home's "Formal Complaints" policy #A-100-43 revised July 2022, interviews the ADOC, the Administrator and other staff.

[522]

WRITTEN NOTIFICATION - REPORTING TO THE DIRECTOR

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm or a risk of harm, immediately reported the suspicion along with the information upon which it was based to the Director.

Rationale and Summary

A) The Ministry of Long-Term Care received a complaint concerning allegations of staff to resident abuse.

Review of the home's notes documented, a staff member reported concerns of alleged staff to resident abuse to another staff member. The staff member emailed the Director of Care (DOC) a summary of the alleged incident, approximately three hours after the alleged incident, and requested the incident be followed up. The DOC replied to the staff member's email and said, the incident would be followed up by the DOC and the Assistant Director of Care (ADOC).

Review of the Ministry of Long-Term Care (MLTC) after hours line and Critical Incident Reporting System (CIS), documented no record of a staff member(s) calling or submitting a critical incident report, to immediately report the alleged staff to resident abuse to the Director.

In an interview, the Administrator and the Director of Care (DOC) both said the alleged incident of staff to resident abuse was not immediately reported to the Director and should have been.

There was moderate risk to the resident when the alleged incident of staff to resident abuse was not immediately reported to the Director.

Sources: The home's abuse and neglect policy, a staff members employee file and interviews with staff and management.

[740]

B) The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm or a risk of harm, immediately reported the suspicion along with the information upon which it was based to the Director.

Rationale and Summary

Review of documentation regarding an investigation involving a staff member noted progress notes related to an incident with a specific resident.

The progress notes indicated that there had been a verbal altercation between the staff member and the resident. The resident reported to another staff member that the staff member they had the verbal altercation with, acted like they were the boss and stated that as a resident they deserved respect.

The progress note indicated that the incident would be reported to the oncoming shift and Director of Care (DOC).

The DOC stated that they had received an email about the incident between the staff member and the resident seven days after the incident. The DOC acknowledged that the incident was abuse.

The DOC indicated a Critical Incident System (CIS) report had not been submitted to the Director and should have been.

Sources:

Review of a resident's clinical record, documentation related to a staff member, and interview with the DOC.
[522]

WRITTEN NOTIFICATION - NURSING AND PERSONAL SUPPORT SERVICES

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 35 (3) (a)

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

Rationale and Summary

An anonymous complaint was received by the Ministry of Long-Term Care related to staffing concerns at the home. The complainant alleged that there were times when there were two PSWs caring for 43 residents.

A) Review of the home's "Staffing Contingency Plan-Nursing" policy noted the normal staffing plan as follows:
Registered Nurse: One on days and one on nights, 12 hour shifts.
Registered Practical Nurse (RPN): Three on days (One per unit and a float), two on evenings (one per unit) and one on nights.
Personal Support Worker (PSW): 10 on days (four care and one bath per unit), eight on evenings (four per unit) and four on nights (2 per unit).

The "Staffing Contingency Plan-Nursing" stated not to replace the first call-in of any shift when the PSW shift assignment was fully staffed.
On days and evenings, if two PSWs called in, one PSW shift would be replaced.
On nights, if the RPN called in, their shift would not be replaced; however, the day RPN could be called in to start at 0530 hours, instead of 0630 hours.
On nights, if a PSW called in, the RPN on one unit would work with one PSW as a team, and the RN Nurse Manager on one unit would work with two PSWs as a team.
On nights, if a PSW called in and the RPN night was not filled the first PSW call would be replaced and if unable to fill, then the RPN would be replaced.

Two staff members acknowledged the Staffing Contingency Plan stated not to replace the first PSW call in and night RPN call in, however the home was currently short staffed, as they currently had 12 open PSW lines, and they attempted to replace any call ins.

The Director of Care (DOC) stated the contingency plan was a minimum of three PSWs per unit and it was up to the registered staff's judgement on how they ensured resident care was provided.

The Administrator stated that the home's contingency plan stated not to replace the first PSW to call in sick and the night RPN if they called in sick.

B) A resident stated it depended on when they rang on how long they would have to wait as staff were so busy. The resident stated at times they had been incontinent as it had taken too long for staff to answer their call bell. The resident stated the home was not fully staffed, especially on the weekends.

A staff member stated that the home currently had three part time and nine full time Personal Support Worker (PSW) positions vacant.

Two staff members stated the home would not run under three PSWs per floor, on days and evenings. If there were below six PSWs working days or evenings, then staff were mandated to stay.

A staff member stated the home struggled on the weekends as scheduled staff were calling in sick. The staff member stated on one weekend there were only three PSWs scheduled on evenings. The staff member stated it was getting to the point where it was unsafe.

The staff member stated they often worked short. The staff member stated most of the summer in the evening there had been two PSWs per floor, instead of the required four per floor, and at times there had been a PSW with a Care Attendant and an agency PSW. The staff member stated residents had to wait for care, and some have had a bowel movement waiting for care. The staff member stated all they could do was clean the resident up and apologize to the resident. The staff member stated one evening there were two PSWs to 43 residents, which was less than the home's required minimum of three PSWs per floor.

A review of the home's Staffing Schedule for July 2022, with a staff member noted 94 unfilled PSW shifts out of 620 shifts (15.1%).

The staff member acknowledged the unfilled shifts. The staff member stated that on three separate dates in July there were only five PSWs working instead of eight between 1430-1830 hours or 1830-2230 hours. On one occasion there were only three PSWs working instead of eight from 1830-2230 hours. The staff member stated on those dates they had no record that staff were mandated to stay, when they should have been as there should have been eight scheduled PSWs working on those shifts, and they were working below the home's requirement of three PSWs per floor.

C) Review of five residents' rooms call bell response times for a two week period in July 2022, with the Building Services Director noted the following occasions where response times were greater than 10 minutes (mins):

64 occasions – 11 to 19 mins
39 occasions – 20 to 29 mins
15 occasions – 30 to 40 mins

4 occasions – 43 to 49 mins
3 occasions – 52 to 58 mins
1 occasion – 1 hour and 7 mins

The Director of Care (DOC) stated that the home's expectation was that staff answered a call bell as soon as possible and if staff could not get to the resident within five minutes, they should alert their team. The DOC stated the call bell rang to all PSWs first, after so long if it was not answered it rang to the RPN, then if it was still not answered it would ring to the RN. The DOC stated the expectation was that staff worked as a team to answer call bells within a reasonable time frame.

The DOC acknowledged the call bell response times were long. The DOC stated after 20 minutes the RN should have looked into those call bells that were ringing that long as no call bell should ever go that long.

By waiting an extended time to have their call bell answered residents were put at risk by not having their care needs attended to in a timely manner, potentially causing the resident to be incontinent or not receiving timely care in an emergent situation.

Sources:
Review of the home's "Staffing Contingency Plan-Nursing" policy #RC-201-101 revised July 2021, the home's July 2022 Staffing Schedule, Call Bell Response times for July 2022, and interviews with a resident, the DOC and other staff.

[522]

WRITTEN NOTIFICATION - BATHING

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 37 (1)

The licensee has failed to ensure that residents were bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Rationale and Summary

A resident's care plan indicated they had a certain preference for bathing. Review of the resident's Documentation Survey Report indicated the resident had received a bed bath, which was not their preference, twice during a specific month.

Another resident's care plan indicated they had a certain preference for bathing. Review of the resident's Documentation Survey Report indicated the resident had received a bed bath, which was not their preference, twice during a specific month.

Another resident's care plan indicated they had two preferences for bathing. Review of the resident's Documentation Survey Report indicated the resident had received a bed bath, which was not their preference, twice during a specific month.

The Director of Care (DOC) acknowledged the residents had been receiving bed baths. The DOC stated all residents were receiving bed baths due to the home's COVID-19 outbreak. The DOC stated first floor residents were isolated to their rooms and bed baths were given. On a specific date, once prevalence testing from second floor came back residents were able to have showers and baths again.

The Administrator stated they had indicated to Huron Perth Health Unit (HPHU) Manager #119 that the home was moving to bed baths and HPHU Manager #119 was agreeable.

The Administrator stated they had sent an email to all staff directing staff to give bed baths.

Review of the Administrator's email stated although second floor residents remained free of any outbreak, those residents were placed under the same precautionary measures as first floor residents. The email stated all residents were only to receive bed baths unless the resident demanded to have a bath in the tub, and it was safe to do so.

HPHU Manager #119 stated to Inspector #705241 that at the initial start of the home's COVID-19 outbreak, they were agreeable for residents to have bed baths for the first couple of days until the contact tracing was determined. HPHU Manager #119 stated it was never suggested to the home to continue with bed baths for residents for the entire outbreak.

Sources:
Review of three residents' clinical records, the home's Outbreak Management Plan 2021/2022, Outbreak Management Meeting Minutes for Ritz Lutheran Villa and Huron Perth Health Unit, COVID-19 Outbreak, Administrator's email correspondence, HPHU Manager #119's email correspondence, and interviews with the DOC, Administrator, HPHU Manager #119 and other staff.

[522]

WRITTEN NOTIFICATION - TRANSFERRING AND POSITIONING TECHNIQUES

NC#019 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 40

The licensee has failed to ensure that a staff member used safe transferring techniques when assisting residents.

Rationale and Summary

The Ministry of Long-Term Care received an anonymous complaint that a staff member was transferring residents who required a two person transfer or lift, independently.

Review of an anonymous complaint that the home received stated the complainant had serious safety concerns for residents as a staff member did lifts and transfers alone which put residents at risk.

A staff member stated they knew of other staff who completed lifts on their own because there were not enough staff.

Another staff member stated that staff working on a specific date reported to them that they witnessed a staff member completing lifts without assistance.

The Assistant Director of Care (ADOC) stated they had received a complaint that a staff member had been completing unsafe lifts and had emailed the staff member regarding safe lifts and transfers and asked the staff member to review the home's Lift Procedures policy.

Sources:
Review of the written complaint to home, email correspondence, the home's "Lift Procedures" policy #RC-201-54 revised July 2021, and interviews with the ADOC, the Administrator and other staff.

[522]

WRITTEN NOTIFICATION - SKIN AND WOUND CARE

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 50. (2) (b) (iii)

The licensee has failed to ensure that a resident with altered skin integrity was assessed by a registered dietitian who was a member of the staff of the home.

Rationale and Summary

Review of a resident's skin assessments noted a resident had two areas of altered skin integrity.

Review of the resident's clinical records noted the resident had not been assessed by a registered dietitian when they developed the areas of altered skin integrity.

A staff member stated residents with altered skin integrity should be referred to and assessed by a registered dietitian.

A staff member reviewed the resident's clinical record with Inspector #522 and acknowledged the resident had not been assessed by a dietitian when they developed the areas of altered skin integrity. The staff member stated they should have made the referral to the dietitian but had forgotten.

Sources:
Review of a resident's clinical record, the home's "Skin and Wound Care Management Protocol" policy #RC-201-95 revised June 2021 and interviews with staff.

[522]

WRITTEN NOTIFICATION - CONTINENCE CARE AND BOWEL MANAGEMENT

NC#011 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 56 (2) (b)

The licensee has failed to ensure that a resident who was incontinent had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on an assessment.

Rationale and Summary

Review of a resident's plan of care noted no direction for staff related to the continence care the resident required, such as the level of assistance required, method of elimination, toileting times, and size of product used.

A staff member stated they were made aware of a resident's continence needs through the resident's care plan and report.

The staff member reviewed the resident's care plan and acknowledged there was nothing specific regarding toileting in the resident's care plan.

Sources:
Review of the resident's clinical record and the home's "Promoting Continence" policy #RC-201-77 reviewed June 2022, observations of the resident and interviews with the resident, the DOC and staff.

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WRITTEN NOTIFICATION - INFECTION PREVENTION AND CONTROL PROGRAM

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

London Service Area Office
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NC #012 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

Rationale and Summary

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On April 27, 2022, Minister's Directive: COVID-19 response measures for long-term care homes was issued to all Long-Term Care Homes (LTCHs) pursuant to s. 184 (1) of the Fixing Long-Term Care Act, 2021. The directive related to the safe operation of LTCHs, specifically to reduce the risk of COVID-19. LTCHS were to practice the health and safety requirements contained in the directive which included personal protective equipment (PPE) requirements.

During the time of the inspection, the home was in a COVID-19 outbreak.

Review of the home's "Personal Protective Equipment" policy noted that staff were to adhere to a strict protocol to remove Personal Protective Equipment (PPE) to prevent contamination. Staff were to remove their eye protection and discard, then remove their mask and discard in a hands free garbage receptacle, then perform hand hygiene. The policy further noted once staff had taken off their PPE it must be discarded and once staff left the home area all PPE must be discarded.

Inspectors #522 and #705241 observed a staff member exit the home, wearing goggles and an N95 mask. While walking through the parking lot, the staff member pulled at the front of their N95 mask and pulled the N95 mask up on top of their head, then the staff member put their goggles on top of their head in front of the N95 mask. The staff member then proceeded to their vehicle with their N95 mask hanging off their back of their head and drove away. At no point was the staff member observed sanitizing their hands.

Inspectors #522 and #705241 observed a staff member exit the home, walk to the parking lot, pull off their goggles and N95 mask and carry them in their hand and enter their car. At no point was the staff member observed sanitizing their hands.

The staff member stated they did not know the home's process on what to do with their PPE when they left the home for break. The staff member stated they had to reuse their PPE, so they wore it out on break and put it back on when they entered the home.

The other staff member stated the home's process was to remove and discard their PPE before exiting the home and sanitize their hands, however they did not complete this.

Sources:
IPAC observations, review of the home's "Personal Protective Equipment" policy #ICP-600-19 revised June 2022, and interviews with staff.

[522]

WRITTEN NOTIFICATION - NOTIFICATION RE: INCIDENTS

NC#013 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22 s. 104 (1) (a)

The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident was immediately notified upon the licensee becoming aware of an alleged, suspected or witnessed incidence of abuse of the resident that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Rationale and Summary

The Ministry of Long-Term Care received a complaint concerning allegations of staff to resident abuse.

The home's policy related to zero tolerance of abuse and neglect stated, the Administrator, Designate and or Department Manager Supervisor would report all alleged incidents to the resident's SDM and or designate, promptly and thoroughly investigate all alleged incidents of abuse, and upon completion, immediately report the results of the investigation to the resident's Substitute Decision Maker (SDM) and or designate. The management team would also communicate with families throughout the process, to prevent further abuse while an investigation was in progress.

Review of the home's notes documented, a staff member reported concerns of alleged staff to resident abuse to another staff member. An additional review of the resident's clinical records showed no documentation of an immediate notification to the resident's substitute decision maker (SDM) when the licensee became aware of the allegation of staff to resident physical abuse.

In an interview with the Administrator and the Director of Care (DOC), they both said, the SDM was not notified as per their policy and legislative requirements and should have been.

There was moderate impact and risk to the resident when the resident's substitute decision maker (SDM) was not notified of the alleged incident of staff to resident abuse.

Sources: The home's abuse and neglect policy, a staff members employee file, the resident's electronic medical records, and interviews with staff and management.

[740]

WRITTEN NOTIFICATION - DEALING WITH COMPLAINTS

NC#014 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 108 (1) 1

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated and resolved where possible, and a response that complied with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation should be commenced immediately.

Rationale and Summary

The Ministry of Long-Term Care received an anonymous complaint related to the unsafe provision of care to residents.

A staff member stated that staff had reported to them that a staff member was providing care to residents in an unsafe manner. The staff member stated they reported this to the staff member in charge and emailed the Assistant Director of Care (ADOC) who was offsite and the Director of Care (DOC) who was off. The staff member stated they had received an anonymous written complaint letter regarding the staff member providing care to residents in an unsafe manner.

The staff member stated that they had not assessed either resident mentioned in the complaint letter to ensure they were not injured after care was provided to the residents in an unsafe manner.

The Assistant Director of Care (ADOC) acknowledged that they had received the anonymous written complaint that a staff member had been providing care to residents in an unsafe manner when they returned to the home after the incident and had received the email the day prior to returning to the home.

The ADOC acknowledged that there was risk of harm to residents as the staff member was providing care to residents in an unsafe manner. The ADOC stated they had not spoken with the staff member regarding the complaint but instead sent them an email regarding adhering to the home's policy and asked the staff member to review the home's policy which they had attached to the email. The ADOC stated they had not received a read receipt from the email they had sent to the staff member and had not followed up with the staff member to ensure they had read the home's policy.

The ADOC acknowledged that they had not investigated part of the complaint and had not spoken with a staff member named in the complaint.

Sources:
Review of the Ministry of Long-Term Care complaint, the home's Complaint Binder, the home's "Formal Complaints" policy #A-100-43 revised July 2022, Complaint to the home, and interviews with the ADOC and other staff.

[522]

WRITTEN NOTIFICATION - DEALING WITH COMPLAINTS

NC#015 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 108 (2) (a)

The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint

Rationale and Summary
A) In August 2022, a copy of an e-mail titled "Concerns" was forwarded to the Ministry of Long-Term Care (MLTC). The e-mail was based on communication between the home's staff and the complainant and referred to several concerns related to a resident's care and safety within the home.

During an interview with the complainant, they indicated they felt their concerns had been dismissed by the home's management and had not been resolved.

Inspector #705241 requested the home's documentation of the concerns that were forwarded to the home. The home's complaints binder was provided, and no documents related to the resident or the concerns in the e-mail were found in the home's complaints binder.

During an interview, the Administrator stated the e-mail was not considered to be a complaint, therefore, it was not documented. They also acknowledged that there was no documentation of the complaint in the home's complaint binder.

Sources: Complaint to MLTC, review of Complaints Binder, interview with complainant, interview with Administrator.

[705241]

B) The Ministry of Long-Term Care received an anonymous complaint that a staff member was completing unsafe transfers in the home.

The Assistant Director of Care (ADOC) acknowledged that they had received the anonymous written complaint that the staff member had been completing transfers on their own.

Review of the home's Complaint Binder noted the nature of the written complaint was not documented. The complaint binder had no record of the complaint.

The ADOC stated they had not documented the written complaint regarding the staff member.

The Administrator stated they did not receive the complaint and found out after the fact.

Sources:

Review of written complaint to home, email correspondence, the home's "Formal Complaints" policy #A-100-43 revised July 2022, the home's Complaints Binder and interviews with the ADOC, the Administrator and other staff.

[522]

WRITTEN NOTIFICATION - DEALING WITH COMPLAINTS

NC#016 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 108 (2) (b)

The licensee has failed to ensure that a documented record was kept in the home that included the date the complaint was received.

Rationale and Summary

A) An e-mail complaint was sent by the complainant and received by the LTC home regarding a specific resident. A review of the home's complaint binder revealed no documentation of the date the complaint was received. The Administrator acknowledged that the e-mail was received but it was not recorded in the home's complaint binder.

Sources: The home's complaints binder, interview with Administrator.
[705241]

B) Review of the home's Complaint Binder noted no documentation of the date the written complaint was received related to a staff member completing unsafe transfers. The complaint binder had no record of the complaint.

The ADOC stated they had not documented the written complaint regarding the staff member.

Sources:

Review of written complaint to home, email correspondence, the home's "Formal Complaints" policy #A-100-43 revised July 2022, the home's Complaints Binder and interviews with the ADOC and other staff.
[522]

WRITTEN NOTIFICATION - DEALING WITH COMPLAINTS

NC#017 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 108 (2) (c)

The licensee has failed to ensure that a documented record was kept in the home that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

Rationale and Summary
A) Review of the home's Complaint Binder noted no documented action taken, no date of the action, no time frames for actions to be taken and no documented follow-up action required related to any complaint received related to the specific resident.

Sources: Review of Complaints Binder, interview with complainant.
[705241]

B) Review of the home's Complaint Binder noted no documentation that included the type of action taken to resolve the written complaint related to s staff member completing unsafe transfers, including the date of the action, time frames for actions to be taken and any follow-up action required. The complaint binder had no record of the written complaint.

The ADOC stated they had not documented the written complaint regarding the staff member.

Sources:
Review of written complaint to home, email correspondence, the home's "Formal Complaints" policy #A-100-43 revised July 2022, the home's Complaints Binder and interviews with the ADOC and other staff.

[522]

WRITTEN NOTIFICATION - DEALING WITH COMPLAINTS

NC#018 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 108 (2) (d)

The licensee has failed to ensure that a documented record was kept in the home that included the final resolution of a complaint.

Rationale and Summary
A) During an interview with the complainant, they indicated they felt their concerns had been dismissed by the home's management and had not been resolved.

Review of Complaints Binder revealed no documentation relating to a complaint resolution for the specific resident.

Sources: Review of Complaints Binder, interview with complainant.
[705241]

B) Review of the home's Complaint Binder noted no documentation that included the final resolution of the written complaint related to a staff member completing unsafe transfers. The complaint binder had no record of the written complaint.

The ADOC stated they had not documented the written complaint regarding the staff member.

Sources:
Review of written complaint to home, email correspondence, the home's "Formal Complaints" policy #A-100-43 revised July 2022, the home's Complaints Binder and interviews with the ADOC and other staff.

[522]

WRITTEN NOTIFICATION - DEALING WITH COMPLAINTS

NC#019 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 108 (2) (e)

The licensee has failed to ensure that a documented record was kept in the home that included every date on which any response was provided to the complainant and a description of the response.

Rationale and Summary
A) Review of the home's Complaint Binder noted no documented dates, response or a description of a response to the complainant for the complaint concerning the specific resident.

Sources: Review of Complaints Binder, interview with complainant.
[705241]

WRITTEN NOTIFICATION - DEALING WITH COMPLAINTS

NC#020 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 108 (2) (f)

The licensee has failed to ensure that a documented record was kept in the home that included any response made in turn by the complainant.

Rationale and Summary
A) No documented response from the complainant was found in the home's complaints binder. During an interview with the Administrator, they stated that the home did not have any specific file related to the complaint.

Sources: Review of Complaints Binder, interview with complainant, interview with Administrator.
[705241]

WRITTEN NOTIFICATION - DEALING WITH COMPLAINTS

NC#021 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 101 (2) (a)

The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint.

Rationale and Summary
On a specific date a resident sustained a fall.

A progress noted indicated when registered staff called the resident's Power of Attorney (POA) to report the fall, the resident's POA was upset and reported concerns related to the fall. The registered staff indicated that they had notified the DOC and sent an update to staff regarding the POA's concerns.

Review of the home's Complaint Binder noted no documentation of the nature of the verbal complaint received from the resident's POA. The complaint binder had no record of the complaint.

The Director of Care (DOC) stated that they had investigated the POA's complaint but had not documented a record of the complaint in the home's complaint binder.

Sources:
Review of the resident's progress notes, email correspondence, the home's Complaint binder, the home's "Formal Complaints" policy #A-100-43 revised July 2022, and interviews with the DOC.

[522]

WRITTEN NOTIFICATION - DEALING WITH COMPLAINTS

NC#022 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 101 (2) (b)

The licensee has failed to ensure that a documented record was kept in the home that included the date the complaint was received.

Rationale and Summary
Review of the home's Complaint Binder noted no documentation of the date the verbal complaint was received from the resident's POA. The complaint binder had no record of the complaint.

The Director of Care (DOC) stated that they had investigated the POA's complaint but had not documented a record of the complaint in the home's complaint binder.

Sources:
Review of the resident's progress notes, email correspondence, the home's Complaint binder, the home's "Formal Complaints" policy #A-100-43 revised July 2022, and interviews with the DOC.

[522]

WRITTEN NOTIFICATION - DEALING WITH COMPLAINTS

NC#023 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 101 (2) (c)

The licensee has failed to ensure that a documented record was kept in the home that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

Rationale and Summary
Review of the home's Complaint Binder noted no documentation that included the type of action taken to resolve the verbal complaint from the resident's POA, including the date of the action, time frames for actions to be taken and any follow-up action required. The complaint binder had no record of the verbal complaint.

The Director of Care (DOC) stated that they had investigated the POA's complaint but had not documented a record of the complaint in the home's complaint binder.

Sources:
Review of the resident's progress notes, email correspondence, the home's Complaint binder, the home's "Formal Complaints" policy #A-100-43 revised July 2022, and interviews with the DOC.

[522]

WRITTEN NOTIFICATION - DEALING WITH COMPLAINTS

NC#024 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 101 (2) (d)

The licensee has failed to ensure that a documented record was kept in the home that included the final resolution.

Rationale and Summary
Review of the home's Complaint Binder noted no documentation that included the final resolution of the verbal complaint from the resident's POA. The complaint binder had no record of the verbal complaint.

The Director of Care (DOC) stated that they had investigated the POA's complaint but had not documented a record of the complaint in the home's complaint binder.

Sources:
Review of the resident's progress notes, email correspondence, the home's Complaint binder, the home's "Formal Complaints" policy #A-100-43 revised July 2022, and interviews with the DOC.

[522]

WRITTEN NOTIFICATION - DEALING WITH COMPLAINTS

NC#025 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 101 (2) (e)

The licensee has failed to ensure that a documented record was kept in the home that included every date on which any response was provided to the complainant and a description of the response.

Rationale and Summary
Review of the home's Complaint Binder noted no documentation that included every date on which any response was provided to the resident's POA and a description of the response. The complaint binder had no record of the verbal complaint.

The Director of Care (DOC) stated that they had followed up with the POA regarding the complaint but had not documented a record of the complaint in the home's complaint binder.

Sources:
Review of the resident's progress notes, email correspondence, the home's Complaint binder, the home's "Formal Complaints" policy #A-100-43 revised July 2022, and interviews with the DOC.

[522]

WRITTEN NOTIFICATION - DEALING WITH COMPLAINTS

NC#026 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 101 (2) (f)

The licensee has failed to ensure that a documented record was kept in the home that included any response made in turn by the complainant.

Rationale and Summary
Review of the home's Complaint Binder noted no documentation that included the response from the resident's POA. The complaint binder had no record of the verbal complaint.

The Director of Care (DOC) stated that they had followed up with the POA regarding the complaint but had not documented a record of the complaint in the home's complaint binder.

Sources:
Review of the resident's progress notes, email correspondence, the home's Complaint binder, the home's "Formal Complaints" policy #A-100-43 revised July 2022, and interviews with the DOC.

[522]

WRITTEN NOTIFICATION - SAFE STORAGE OF DRUGS

NC#027 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 138. (1) (a) (ii)

The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

Rationale and Summary

Inspector #522 observed an unlocked and unattended medication cart with the keys still in the lock in the hallway outside the second floor dining room. Residents were observed in the hallway walking to the dining room. Inspector #522 waited several minutes beside the medication cart and observed a registered staff member come out of a resident room at the end of the North hallway.

The registered staff member acknowledged they had left the cart unlocked with the keys in the lock and stated they were in a resident room performing a treatment and had not taken the cart with them.

The same day, Inspector #522 observed an unlocked and unattended medication cart in the first floor west hallway along a wall outside of the dining room. Inspector #522 waited by the medication cart several minutes for the registered staff member to return to the medication cart.

Sources:
Observations of medication carts on home areas, review of the home's "Medication Administration & Security & Accountability" policy #NA-200-26 revised June 2022, Pack4U "Medication Administration Procedures" policy 9-1 dated 2018, and interviews with two registered staff members and other staff.

[522]

WRITTEN NOTIFICATION - MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC#028 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 135. (1) (a)

The licensee has failed to ensure that every medication incident involving a resident was documented.

Rationale and Summary

A resident was prescribed a medication prior to entering the facility. The resident was ordered the medication to be administrated for a specific duration, then the medication was to be reassessed. The medication was not reassessed as ordered and instead was discontinued, without consulting the prescribing physician.

The Administrator and the Director of Care (DOC) stated a medication incident report was not completed.

The home's Medication Incident Reporting Policy stated that a medication incident report was used to document any incident involving a medication or an adverse effect. It further stated medication incidents were to be investigated.

Sources: Review of pharmacy medication incident reports, the resident's progress notes, the home's Medication Incident Reporting Policy 10-6 and staff interviews.
[705241]

WRITTEN NOTIFICATION - MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC#029 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 135. (1) (b)

The licensee has failed to ensure that the medication incident involving the resident was reported to the resident's substitute decision-maker and to the pharmacy provider.

Rationale and Summary

The resident's substitute decision-maker stated they were not informed that the reassessment was not completed and that the resident's medication had been discontinued.

Pharmacy Operations Manager #120 indicated a medication incident report was not submitted to the pharmacy related to the discontinuation of the resident's medication.

The home's Medication Incident Reporting Policy stated that medication incidents were to be reported to all relevant parties and investigated.

Sources: Review of pharmacy medication incident reports, the resident's progress notes, the home's Medication Incident Reporting Policy 10-6 and interviews with the resident's POA and staff.

[705241]

COMPLIANCE ORDER [CO #001] - PLAN OF CARE

NC#030 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 s. 6 (7)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee has failed to comply with LTCHA, 2007 s. 6 (7).

The licensee must ensure:
A) That the care set out in the plan of care relating to the reassessment of medications is provided to a specific resident as specified in the plan.
B) The physician is informed when the specific resident has a medication that requires re-assessment so the resident can be reassessed, and their plan of care reviewed and revised for the resident to receive the medication.
C) When the specific resident is prescribed any medication that requires re-assessment for re-ordering, that the reassessment date is clearly documented, the prescriber is informed of the re-assessment date and the medication re-ordered if needed.

Grounds

Non-compliance with: LTCHA, 2007 s. 6 (7)

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

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care that a resident did not receive a prescribed medication due to the home's failure to re-assess the resident for the medication to be ordered.

The resident was prescribed a medication prior to entering the facility. The resident was ordered the medication to be administrated for a specific duration, then the medication was to be reassessed. The medication was not reassessed as ordered and instead was discontinued, without consulting the prescribing physician.

Review of the resident's care plan in Point Click Care (PCC) revealed there were no goals or interventions related to the monitoring and the re-assessment of the medication.

In an interview with Attending Physician #115, they acknowledged a medication reassessment of the resident should have occurred and that the reassessment had been missed.

In an interview with the DOC, they confirmed the resident had not been re-assessed for the medication and that it had not been reordered.

Sources: Review of complaint Intake, the resident's progress notes, assessments, care plans in PCC and staff interviews.

[705241]

This order must be complied with by November 9, 2022

COMPLIANCE ORDER [CO #002] – SAFE AND SECURE HOME

NC #031 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 5

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee has failed to comply with FLTCA, 2021 s. 5.

The licensee must ensure:
A) A specific resident is not restrained.
B) The specific resident must be assessed, and alternative interventions implemented to manage the resident's behaviours.
C) The specific resident's assessments and the interventions trialled must be documented, including their effectiveness.
D) Registered Staff and Personal Support Workers working on the first floor receive retraining on the minimizing of restraints and confinement.
E) Training must be documented, including the name of the staff members and the date the training occurred.

Grounds

Non-compliance with: FLTCA, 2021 s. 5

The licensee has failed to ensure that the home was a safe and secure environment for a specific resident.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care (MLTC) that a resident was being confined to a specific space. The complainant stated that the resident had cognitive decline, was at risk for falls and was unable to communicate their needs.

On several occasions during the inspection, Inspector #705241 observed that the resident was confined to a specific space.

The Director of Care (DOC) acknowledged the resident was confined to a specific space during the COVID-19 outbreak within the home.

A staff member confirmed the resident was confined to a specific space.

The resident was at risk for falls, had cognitive decline and was unable to leave the specific space. This increased the resident's risk of contracting COVID-19 and increased risk of delay in appropriate care interventions being implemented.

Sources: Review of complaint Intake, e-mail correspondence, observations, the resident's progress notes, assessments, HPHU, and staff interviews.

[705241]

This order must be complied with by November 9, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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