Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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: March 21, 2024

Inspection Number: 2024-1035-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Southbridge Cornwall, Cornwall

Lead Inspector	**Inspector Digital Signature**
Jessica Lapensee (133)	Jessica Lapensee Digitally signed by Jessica Lapensee Date: 2024.04.03 13:08:41 -04'00'

Additional Inspector(s)
Laurie Marshall (742466)
Megan MacPhail (551)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 27, 28 and 29, 2024, and March 1, 4, 5, 6, 7, 11 and 14, 2024.
The inspection occurred offsite on the following date(s): March 12 and 13, 2024.

The following intake(s) were inspected:

• Intake: #00103504 / Critical Incident System (CIS) report 3063-000079-23 was related to an allegation of staff to resident neglect.
• Intake: #00104119 was a Follow-up to Compliance Order (CO) #001 from

inspection 2023-1035-0003, issued under O. Reg. 246/22, s. 12 (1) 3, with a compliance due date (CDD) of January 15, 2024.
• Intake: #00104120 was a Follow-up to CO #004 from inspection 2023-1035-0003, issued under FLTCA, 2021, s. 82 (2), with a CDD of January 15, 2024.
• Intake: #00104121 was a Follow-up to CO #003 from inspection 2023-1035-0003, issued under O. Reg. 246/22, s. 75, with a CDD of January 26, 2024.
• Intake: #00104122 was a Follow-up to CO #002 from inspection 2023-1035-0003, issued under O. Reg. 246/22, s. 20 (a), with a CDD of February 15, 2024.
• Intake: #00106148 / CIS report 3063-000004-24 was related to a written complaint about the care of a resident.
• Intake: #00106419 / CIS report 3063-00006-24 was related to an allegation of resident to resident abuse.
• Intake: #00107346 / CIS report 3063-000011-24 was related to an allegation of resident to resident abuse.
• Intake: #00107444 was a complaint related to a shortage of linens in the home.
• Intake: #00107824 was a complaint related to concerns about the care of a resident.
• Intake: #00108061 / CIS report 3063-000015-24 was related to a disease outbreak.
• Intake: #00109704 / CIS report 3063-000021-24 was related to a disease outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1035-0003 related to O. Reg. 246/22, s. 12 (1) 3. inspected by Jessica Lapensee (133)

Order #004 from Inspection #2023-1035-0003 related to FLTCA, 2021, s. 82 (2)

inspected by Megan MacPhail (551)

Order #002 from Inspection #2023-1035-0003 related to O. Reg. 246/22, s. 20 (a)
inspected by Jessica Lapensee (133)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #003 from Inspection #2023-1035-0003 related to O. Reg. 246/22, s. 75
inspected by Megan MacPhail (551)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care- Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented relating to a recurring intervention, for three months, for a resident.

Rationale and Summary
A resident's plan of care indicated that the resident was to have an intervention at defined intervals during specified periods of time each day.

Review of Point of Care (POC) identified that there were missing entries by care staff relating to the intervention for three months.

Interview with a Personal Support Worker (PSW) reported that the expectation of care staff was to document tasks in POC and that the resident had the intervention at defined intervals.

The Director of Care (DOC) confirmed staff were required to document tasks in POC which included the recurring intervention.

Failing to ensure that the provision of the care set out in the plan of care for the resident was documented increased the risk that the recurring intervention was not completed for the resident.

Sources: Care plan, POC, interview with a PSW and the DOC. [742466]

WRITTEN NOTIFICATION: Conditions of License

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is

subject.

The licensee has failed to comply with Compliance Order (CO) #003 from inspection 2023-1035-0003, served on December 12, 2023, with a compliance due date of January 26, 2024.

The requirement to have a Registered Dietitian (RD), who was a member of the staff of the home and who was on site, was not fully complied with.

Rationale and Summary
The RD worked at the home since November 15, 2023. They worked 80 hours per month to carry out clinical and nutritional care duties. The RD worked off site only, and they had not worked at the home. In 2024, the Corporate RD provided 15.5 hours of on-site coverage.

The Administrator stated that the home was actively seeking to hire an RD who would work on site.

Sources: Residents' health care record and interviews with the RD and the Administrator. [551]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is

required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Directives by Minister

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

Rationale and Summary

In accordance with an identified minister's Directive and an associated guidance document, the licensee was required to ensure that staff wear the recommended personal protective equipment (PPE) when providing direct care to residents that may be infected with a specified pathogen.

On an identified day, four resident rooms in a resident home area (RHA) had signage posted for a specific type of Additional Precautions (APs).

As per the signage "PPE Requirements based on Additional Precautions Type", the specific type of APs required the application of a gown, N95 mask, face shield and gloves.

The Infection Prevention and Control (IPAC) Lead stated that until the results of the lab tests for all four residents were received, and the pathogen was confirmed, symptomatic residents were placed on the specific type of APs. This was reflected in the home's related policy which stated that when the risk is unknown, not yet assessed or unable to be assessed (such as when results were pending), a symptomatic resident should be placed on the specific type of APs, as if they may be infected with the specified pathogen.

At an identified time on the identified day a resident, who was symptomatic, was in the doorway of their room. They stated that they required care and were waiting for assistance. A PSW who was in a neighboring room, went to the resident's room, interacted with the resident and told the resident that they would be back. The PSW was not wearing a gown, N95 mask, face shield or gloves. They were wearing a surgical mask only.

Seven minutes later, another PSW was observed in the resident's room, interacting with the resident. The PSW was not wearing a gown, N95 mask, face shield or

gloves. They were wearing a surgical mask only.

Until the specified pathogen was ruled out, residents were placed on the specific type of Additional Precautions, as if suspected as being infected with the pathogen. By not applying the required PPE, the staff could have been exposed to infectious agents and risked transmitting and infecting other residents and staff.

Sources: Observations, interview with the IPAC Lead and a related policy. [551]

WRITTEN NOTIFICATION: Doors to non-residential areas

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that the third floor servery dish room door was locked when the door was not being supervised by staff.

Rationale and Summary
On March 4, 2024, the inspector pushed on the 3rd floor servery dish room door and the door opened. The inspector proceeded into the servery and observed two dietary aids sitting at a table in the dining room. They explained to the inspector that they were taking their break, and, that the dish room door was always locked in that they always needed a key to enter but did not need a key to lock the door when they left the area. One of the dietary aids (DA) and the inspector observed that the

door handle itself was locked, however the door was not latching when allowed to close under its own weight. The DA indicated this was a maintenance issue and would report it.

On March 6, 2024, the inspector found the door unlatched and therefore unlocked again. It was noted that there were two staff members in the front servery at the time and a DA entered the dish room within moments of the inspector arriving. The DA pointed out that there were now signs on the inside of the door, reminding staff to pull the door shut when exiting. Upon exiting the dish room the inspector met a maintenance worker and they confirmed there was a problem with the door latching and that they had done some adjustments on March 5, 2024. The maintenance worker made further adjustments, in the presence of the inspector, and the issue was resolved.

As such, there had been risk of residents gaining unsupervised access to the third floor servery dish room.

Sources: observations and interviews with dietary aid and maintenance worker. [133]

WRITTEN NOTIFICATION: Resident- Staff Communication and Response System

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (g)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system (RSCRS), that, in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

Rationale and Summary
The home was equipped with an RSCRS whereby calls made by residents went to phones that all care staff were required to carry at all times. When a call was received by a phone, there was to be an audible noise to alert staff to look at their phone. In addition, the home installed marquis display boards on the care units as an enhancement to the RSCRS in February 2024. The marquis boards were programmed to initially emit three tones upon receipt of a call, and the sound recurred approximately three to four minutes later.

On February 29, 2024, the inspector met a representative from the Southbridge Information Technology (IT) department, who explained that they and another IT person had been in the home that week to "fine tune" the new marquis display board system as there has been some reported issues with the functionality of the system.

On a Resident Home Area (RHA), on an identified day in March 2024, the inspector met a staff person who had just confirmed during an RSCRS audit that the new marquis display boards were not receiving calls. The inspector proceeded to observe shift change and heard a Registered Nurse (RN) make a phone call, stating that there was an active call from a resident that required response. It was subsequently confirmed that two PSWs in the resident's hallway were carrying phones that were not making sounds, nor was the RN's phone. The RN explained they had visually checked their phone during the shift change and that is how they

became aware of the active call from the resident.

On an RHA, on an identified day in March 2024, a PSW was carrying phone #1. The phone displayed a test call but it did not make a sound. The PSW and the inspector proceeded to a lounge, made another test call, and this time the phone made a sound. It was noted that by this time that the marquis board system malfunction had been rectified.

On an RHA, on an identified day in March 2024, a PSW was carrying phone #4 and the phone displayed a test call but it did not make a sound.

On an RHA, on an identified day in March 2024, a PSW was carrying phone #1 and the phone did not display a test call and did not make a sound as the phone was reconnecting. After several minutes, the PSW logged into phone #3 and that phone did display the test call and made a sound.

On an RHA, on an identified day in March 2024, the inspector arrived on the unit and noted an active call on a marquis for a resident. The inspector proceeded to the bedroom and could hear a staff person assisting the resident. The inspector did not hear a sound from a staff phone, yet the call remained active. A PSW exited the room and explained they were having difficulty cancelling the call and that is why it remained active. The PSW explained that their phone (#4) had displayed the call but had not made a sound. The PSW explained that they had been seated at the nurses' station, doing documentation, and at one point they looked up and saw the active call on the marquis display board.

On an RHA, on an identified day in March 2024, a PSW was carrying phone #4 and it did not display a test call and did not make a sound as the PSW was logged out of their phone. The PSW explained this also happened to them yesterday, and its not

unusual they lose a Wi-Fi connection and the phone logs them out. The PSW indicated that as a result they would like to rely on the marquis boards however they do not always seem to be working either. The PSW referred to the system malfunction that had recently occurred, and also to the recent work that was done on the system.

On an RHA, on an identified day in March 2024, a PSW was carrying phone #2 and it was not making a sound in response to an active call. The PSW exited the program, went back in, and then the phone started making a sound. Another PSW was carrying phone #1. The phone displayed a test call and it made a sound. The PSW indicated that earlier in their shift, their phone did not make a sound in response to an active call. The inspector inquired about the possibility of relying exclusively on the marquis display boards as audible notification. The PSW indicated that if they could hear the sound throughout the hall then there would be no problem however the halls are long and there are no marquis boards at the ends. The PSW said "When the phones work it's great but when they don't it's such a worry. The marquis is not enough, I don't think it rings loud enough and it should ring all of the time."

On an RHA, on an identified day in March 2024, the inspector observed an active call on the hallway marquis. Two PSWs in the area confirmed that their phones were displaying the call but were not making a sound. One of the PSWs explained that it seemed like after a while of not using the phone there is no sound so you have to exit the program and go back in and then it will make a sound. Both PSWs did so and then both of their phones made a sound. The PSWs were carrying phone #3 and #4.

As such, there was risk that response time to calls from residents could be delayed or missed as staff rely on the phones they are required to carry are the primary way they will be audibly alerted to a call.

Sources: Observations of care staff phones and the marquis display boards, interviews with PSWs and other staff. [133]

WRITTEN NOTIFICATION: Falls prevention and management

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

Non-compliance with: O. Reg. 246/22, s. 54 (3)

Falls prevention and management

s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

The licensee has failed to ensure that supplies of an identified type of protective equipment were readily available to residents in the home.

Rationale and Summary

Review of the care plans for two residents identified that both residents required the protective equipment.

Review of the policy for Falls Prevention and Management Program (RC-15-01) indicated that care staff are required to implement any strategies and interventions as outlined on the resident's plan of care.

Progress notes for the first resident identified that the protective equipment was not available on two identified days in February 2024 and two identified days in March 2024.

Progress notes for the second resident identified that the protective equipment was

not available on one identified day in February 2024 and two identified days in March 2024.

During an interview conducted by Inspector #133, a Personal Support Worker (PSW) stated that they had reported to registered staff that the protective equipment was not available for the two residents.

A Registered Practical Nurse (RPN) reported that there was a shortage of the protective equipment on the unit. The RPN also reported that the protective equipment was in the plan of care for both residents. The RPN reported that there were other residents on the unit that required the protective equipment and they did not have them readily available.

The Director of Quality and Risk (DQR) reported that they were aware of a couple of instances where residents did not have the required protective equipment and the direction to staff was to go and check for them in a specified area which was outside of the care unit.

As such, failure to ensure that the protective equipment was readily available for the two residents increased the risk of injury to both residents.

Sources: Care plans for two residents, progress notes for two residents, Falls Prevention and Management Program (RC-15-01-01, March 2023), interview with a PSW, an RPN and the DQR. [742466]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

A) The licensee has failed to ensure that Routine Practices were followed in the Infection Prevention and Control (IPAC) Program with regards to hand hygiene (HH).

The licensee has failed to ensure that Routine Practices were followed in the IPAC Program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, the licensee did not ensure that Routine Practices included at a minimum, hand hygiene (HH) at the four moments of HH, as is required by Additional Requirement 9.1 (b) of the IPAC Standard.

Rationale and Summary
There was a disease outbreak on a resident home area (RHA) and all residents were eating in their rooms. A PSW was delivering lunch meals to the residents in disposable containers from a cart.

The PSW exited a room, where one type of Additional Precautions (APs) was in place. The PSW removed their gown and did not perform HH. The PSW then proceeded to deliver a meal to another room, where a second type of APs were in place, and they did not perform HH. After the second room, the PSW delivered a meal to a third room, and they did not perform HH.

The PSW did not perform HH after removing their gown, and before or after contact with the residents and/or their environments in the three rooms.

By not performing HH, as required by the four moments of HH, the risk of transmitting infectious agents may have increased.

Source: Observations and the Four Moments of HH. [551]

B) The licensee has failed to ensure that Additional Precautions (APs) were followed in the IPAC Program with regards to glove use and eye protection.

The licensee has failed to ensure that APs were followed in the IPAC Program in accordance with the IPAC Standard. Specifically, the licensee did not ensure that APs included the appropriate selection, application, removal and disposal of PPE, as is required by Additional Requirement 9.1 (f) of the IPAC Standard.

Rationale and Summary
As per the signage "PPE Requirements based on Additional Precautions Type", one type of APs required the application of a gown, N95 mask, face shield and gloves. A second specified type of APs required the application of a gown, face mask, face protection and gloves.

1) On an identified day in February 2024, in a resident home area (RHA), signage for the first type of APs was posted for one room, and signage for the second type of AP was posted for three other rooms.

At an identified time, a PSW (the first) assisted a resident (the first) in the room where signage was posted for the first type of APs. The PSW did not wear eye protection. After assisting the resident, the PSW went to assist a second resident in a room where the second type of APs were in place. The PSW did not wear eye protection.

Shortly after the above, a Registered Nurse (RN) and a different PSW (second PSW)

entered the room where signage for the first type of APs was posted, to assist the first resident. The RN and the PSW did not wear eye protection.

The second PSW stated that in a room with two residents, with signage for the second type of APs, they did not know which resident was on the APs. A resident in the room activated their call bell to request assistance. The PSW did not wear eye protection while in the room and when they assisted the resident to the toilet. On that day, and the following day, the first PSW stated that they did not know why the APs signage was posted for the room as neither resident was on APs.

2) On an identified day in March 2024, a PSW exited a room where one type of APs were in place. The PSW was wearing gloves. The PSW then went into a second room, where a second type of APs were in place. They touched the residents' environment in the second room, got linens and went back into the first room, wearing the same gloves. The PSW then proceeded to the residents' shared washroom.

3) On the following day in March 2024, the same PSW referenced above delivered a lunch meal to the residents in a room where a type of APs was in place. For PPE, the PSW was wearing a gown and a surgical mask. They were not wearing eye protection or gloves.

By not ensuring the appropriate removal and disposal of gloves, followed by hand hygiene, upon exiting the room, the same PSW referenced above may have transmitted infectious agents.

By not ensuring the appropriate application of eye protection when interacting with residents on Additional Precautions (APs), staff were at risk of exposure to infectious agents and transmitting it to others.

Sources: Observations and PPE Requirements based on Additional Precautions Type signage. [551]

C) The licensee has failed to ensure that APs were followed in the IPAC Program with regards to point-of-care signage.

The licensee has failed to ensure that APs were followed in the IPAC Program in accordance with the IPAC Standard.

Specifically, the licensee did not ensure that APs included point-of-care signage indicating that enhanced IPAC control measures were in place, as is required by Additional Requirement 9.1 (e) of the IPAC Standard.

Rationale and Summary
On an identified day in February 2024, a resident was symptomatic. Over the next two days, a yellow door hanger with PPE was observed on the door of the resident's room. There was no point-of-care signage indicating that APs were in place. Three days later, AP signage was posted on the door of the room.

On an identified day in February 2024, another resident was symptomatic and a type of APs were put into place. On the following day, the IPAC Lead stated that a lab result for the resident was pending, therefore they were on a type of APs, until the pathogen causing the illness was known. There was no point-of-care signage indicating that the resident was on APs when the lab result was pending. On the third day the pathogen was confirmed and the type of APs in place for the resident was updated. On the fourth day, there was no point-of-care signage indicating that the resident was on the updated type of APs.

In the absence of point-of-care signage, staff may not have been clear about what PPE to wear when providing care to the residents.

Sources: Observations, resident health care record and interview with the IPAC Lead. [551]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the response provided to a person who made a complaint included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary
A critical incident system (CIS) report was submitted to the Director, as required by the Fixing- Long Term Care Home Act, 2021, s. 26 (1) (c). The written complaint was concerning the care of a resident.

The Director of Care (DOC) provided a written response to the person who made the complaint. The written response did not include the Ministry's toll-free number for making complaints, it's hours of service and contact information for the patient

ombudsman.

The DOC stated that the home revised their response template to include the Ministry's toll-free number and the contact information for the patient ombudsman, and this was noted in two subsequent CIS report submissions. However, the hours of service for making complaints to the Ministry was not included in the response template.

Sources: Interview with the DOC and CIS report 3063-000004-24. [551]

COMPLIANCE ORDER CO #001 Availability of linen supplies

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 48
Availability of supplies
s. 48. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 48 [FLTCA, 2021, s. 155 (1) (b)]:

The plan shall include but not be limited to:

a) a review of the organized laundry program including hours of operation, quotas, discard and rewash processes, and methods of requesting additional linen supplies; and

b) a review of the storage of clean linen supplies, ensuring that the supplies are always readily available on the care units to meet the personal care needs of the residents; and

c) a review of processes in place to distribute clean linen supplies to the care units and to resident bedrooms in order for the next shift to have supplies readily available to meet the personal care needs of all residents; and

d) once a week audits of the availability of clean linen supplies on the care units prior to each shift and making changes based on the audits and the reviews required by a), b) and c) until this order has been complied; and

e) determining which residents have any degree of independence in regards to their personal care and ensuring that on every shift those residents have the linen supplies they need; and

f) determining which residents require a soaker pad due to incontinence and providing the required amount for each shift; and

g) Documentation to support action has been taken in regards to (a) through (f), and any other action that the home determines is necessary in order to ensure that linen supplies are readily available to meet the personal care needs of the residents.

Documentation is to continue until such time that this compliance order has been deemed to be complied by the MLTC.

Please submit the written plan for achieving compliance for inspection #2024-1035-0001 to Jessica Lapensee (133), LTC Homes Inspector, MLTC, by email to ottawadistrict.mltc@ontario.ca by April 8, 2024.

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

Grounds
The licensee has failed to ensure that supplies specific to washcloths, towels and soaker pads are readily available at the home to meet the personal care needs of residents.

The inspector interviewed care staff throughout the home over the course of the inspection regarding the availability of linen supplies such as washcloths and towels Thirteen Personal Support Workers (PSWs) and a Registered Practical Nurse all spoke to the inspector about routine shortages of readily available face cloths, peri cloths, hand towels, bath towels, and soaker pads required for the personal care needs of the residents. Overall, care staff indicated they lost time for caring for residents due to searching for linen supplies.

On an identified day in February 2024, a laundry aid (LA) explained that laundry starts at 0800 hours and sorting and washing linens is the immediate priority as all that has been received is what goes back out to the units in the afternoon. Each care unit gets one stocked cart per day. The LA indicated that day shift care staff often come to the laundry room looking for clean towels and cloths. There are no extra face cloths or peri cloths however by mid-morning some may be ready to go back out and when this occurs, it affects the supply that will be available for the evening shift.

On an identified day in March 2024, two PSWs indicated that due to shortages of

cloths and towels at the start of their day shift, they had to go searching to find supplies outside of the resident home area (RHA). Some mornings nothing can be found. Both PSWs indicated that often they cannot start taking care of residents for about half an hour after their shift begins as a result of the time spent searching. One of the PSWs indicated they sometimes use bath towels to do peri care for residents and to wash residents in the bathtub.

On an identified day in March 2024, a PSW indicated that at the start of the day shift, there were no cloths of towels in the laundry cart and only a few residents had any in their bedrooms. A second PSW indicated it was the same on their RHA and as a result they used wet wipes as face cloths for at least three residents and they felt badly as some got a good wash and some did not. The second PSW was concerned as there were two more residents to be bathed that morning and there were no more bath towels on the unit. A third PSW indicated they ran out of bath towels on their RHA and had to leave and wait for the laundry room to open in order to get more, which caused them to be late getting started with breakfast.

On an identified day in March 2024, a PSW indicated their RHA had two face cloths, six peri cloths and a stack of hand towels to start the shift, and only a few residents had any supplies in their rooms. Searching for cloths and towels delayed the PSW from providing morning care to the residents. They referred to a routine shortage of soaker pads and a resident who should have one but did not.

On an identified day in March 2024, two PSWs indicated their RHA was short of cloths, towels and soaker pads. The first PSW indicated only a few of their residents had cloths in their rooms and therefore they were providing morning care with hand towels and bath towels, wetting one end, and drying with the other. The second PSW indicated they had to leave their RHA that morning to search for bath towels so they could bathe residents. The second PSW referred to a resident that needed a

soaker pad but did not have one, and informed that on the previous morning, they found another resident with a folded flannel sheet under them instead of a soaker pad.

On an identified day in March 2024, a resident indicated that their PSWs often have to leave them and search for soaker pads and there is not always a soaker pad for them.

On an identified day in March 2024, between 0815 hours and 0900 hours the inspector observed in 21 resident rooms (of 32) they could find two face cloths, two peri cloths and eight hand towels. In a resident's bedroom, there was a white face cloth covered with brown matter in a wash basin. The inspector found six face cloths, three peri cloths, five hand towels, five bath towels and no soaker pads in the clean utility room and on the linen carts.

On an identified day in March 2024, two PSWs indicated they routinely use folded flannel sheets instead of soaker pads and that morning, a resident had such a sheet under them. The PSWs indicated they have used flannel sheets to dry residents due to a lack of bath towels. The inspector observed the clean utility room and linen carts in the RHA and found no soaker pads.

On an identified day in March 2024, a resident indicated it is not unusual that they have no cloths or towels for their morning care. This occurred within the last week, and it took all day for staff to bring them more cloths and towels. The resident stated they don't want to have to ask for cloths and towels.

On an identified day in March 2024, a PSW indicated they used three packs of wipes to provide morning care to their residents due to a shortage of cloths and towels on their RHA.

On an identified day in March 2024, a resident indicated that frequently they do not have the cloths and towels they need to clean themselves before going to breakfast. The previous day, they had none.

On an identified day in March 2024, a resident indicated care staff are always having to search for soaker pads, it can take a long time and sometimes there are none. They have had folded flannel sheets under them instead of a soaker pad. Related to their bathing process, there hasn't been any hand towels for them to use lately.

On March 14, 2024, the Environmental services Manager (ESM) confirmed that a linen count had been conducted in the home on March 4th, 2024. Additional face cloths and peri cloths had been ordered as a result. The ESM indicated they were working towards establishing a quota system for the home.

As such there was risk of not meeting the resident's personal care needs as supplies specific to cloths and towels and soaker pads were not readily available to care unit staff.

Sources: Interviews with thirteen Personal Support Workers, other staff, residents, observations of readily available washcloths, towels and soaker pads on the care units, and review of the linen count related document as provided by the Environmental Services Manager. [133]

This order must be complied with by May 21, 2024

COMPLIANCE ORDER CO #002 Responsive behaviours

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

a) Provide education and training for all Personal Support Workers (PSW) on all applicable policies, procedures, and appropriate practices pertaining to documentation of the Dementia Observation Scale (DOS), and;

b) A written record of this training shall be kept and include staff who participated in the training, registered staff who provided the training and copies of training material must be kept, and;

c) For each resident on all home areas that require DOS mapping, a biweekly audit shall be conducted by a member of the home's management team to ensure that DOS documentation is being completed on all shifts, and;

d) The biweekly audits shall continue, including corrective actions taken, until this order is complied, and;

e) A written record must be kept for steps (a), (b),(c) and (d), until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

A) The licensee has failed to ensure that documentation was completed in the Dementia Observation Scale (DOS) to respond to the needs of the residents regarding interventions to mitigate the behaviours of a resident.

Rationale and Summary

Progress notes from an identified day in January 2024 indicated that one resident abused a second resident.

Review of the Responsive Behaviors Policy indicated that Dementia Observation System (DOS) is used to document and observe behaviour over time and allow for a thorough evaluation of any pattern of behaviour identified thus facilitating a comprehensive plan and care staff are required to complete accurate documentation in the resident's health record when behaviors are observed.

Review of Point of Care (POC) for one month identified that there were multiple missing entries for DOS monitoring of the resident on day and evening shifts including the day that the resident abused the second resident.

A Registered Practical Nurse (RPN) confirmed that staff were required to complete DOS monitoring in Point of Care (POC).

The Director of Care (DOC) confirmed that DOS monitoring is used as a behaviour assessment tool and staff were required to document in DOS. The DOC confirmed that the resident had extensive behaviours and at the time of the incident there were no identifying triggers.

Failure to fully complete the DOS and documenting the residents' responsive

behaviours led to an increased risk of not taking actions to respond to the needs of the resident, including assessments, reassessments, and interventions. This posed

an increased risk to other residents' due to altercations that occurred. [742466]

B) The licensee has failed to ensure that documentation was completed in the Dementia Observation Scale (DOS) to respond to the needs of the residents regarding interventions to mitigate the behaviours for a resident.

Rationale Summary
Review of the resident's plan of care indicated that the resident required an intervention due to their unpredictable behavior towards other residents and DOS mapping was to be done as needed to document behaviours and potential causes.

Review of DOS mapping in Point of Care (POC) for two months identified that there were several missing entries on day and evening shifts.

During an interview with a PSW they confirmed that DOS mapping was required to be completed every shift.

The DOC reported that staff were required to complete DOS on all shifts and that they were aware that staff had not been completing documentation.

As such, by not fully completing the DOS and documenting the residents' responsive behaviours led to an increased risk of not taking actions to respond to the needs of the resident, including assessments, reassessments, and interventions. This posed an increased risk to other residents.

Sources: Care plan, DOS in POC, interview with a PSW and the DOC. [742466]

This order must be complied with by May 21, 2024

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;
(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

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.