Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 14, 2022	2021_916168_0011 (A1)	010632-21, 011701-21, 011762-21, 012519-21, 012800-21, 013207-21, 013353-21, 013354-21, 013358-21, 013454-21, 013857-21, 014529-21, 014808-21, 015127-21, 015166-21, 015447-21, 015659-21, 016762-21	Complaint

Licensee/Titulaire de permis

Albright Gardens Homes, Incorporated
5050 Hillside Drive Beamsville ON L0R 1B2

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

Albright Gardens Homes, Incorporated
5050 Hillside Drive Beamsville ON L0R 1B2

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

Amended by LISA VINK (168) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee Order Report amended to adjust compliance due date of Compliance Order (CO) #001.

Issued on this 14th day of January, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by LISA VINK (168) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 22, 25, 26, 27 and 28, 2021 and November 1, 2, 3, 4, 5, 7, 9, 10, 16 and 17, 2021.

This inspection was completed for the following intakes:

012800-21 - related to nursing and personal support services;

013454-21 - related to nursing and personal support services;

010632-21 - related to falls prevention and management;

013857-21 - related to nursing and personal support services;

013353-21 - related to nursing and personal support services;

013354-21 - related to nursing and personal support services;

016762-21 - related to falls prevention and management;

011762-21 - related to bathing, transferring and positioning and nursing and personal support services;

012519-21 - related to nursing and personal support services;

013358-21 - related to plan of care, nutrition and hydration and nursing and personal support services;

013207-21 - related to falls prevention and management;

015447-21 - related to nursing and personal support services;

011701-21 - related to safe and secure environment;

015659-21 - related to plan of care;

014529-21 - related to falls prevention and management, pain management, plan of care, laundry services and nursing and personal support services;

014808-21 - related to falls prevention and management;

015166-21 - related to staffing and care standards; and

015127-21 - related to staff qualifications, training, dining and snack services, bathing and nursing and personal support services.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), screeners, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), housekeeping staff, recreation staff, nurse consultant, staffing coordinator, Niagara Region Public Health staff, laundry aide, Food Services Supervisor, Director of Dietary Services, Resident Assessment Instrument (RAI) Coordinator, dietary aides, occupational therapist (OT), physiotherapist (PT), a physician, Director of Programs and Services, family members and residents.

During the course of the inspection, the inspectors observed the provision of care and services, reviewed records, including but not limited to, meeting minutes, staffing schedules, clinical health records, menus, production sheets, complaint records, and investigative notes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.

- **14 WN(s)**
- **10 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

The Ministry of Long-Term Care (MOLTC) received a number of complaints regarding shortages of staff in the home. These complaints were received from staff, family members and residents. The complaints identified resident specific care needs which staff were not able to meet, or not within the required time frame due to the staffing complement.

The home had a licensed capacity of 231 beds.
The Daily Staffing Report provided a breakdown of staff for the nursing department by role, shift and resident home area.
When the home had a full resident occupancy their planned staffing mix, as identified in the Daily Staffing Report, which did not include management was: 2 RNs, 8 RPNs, and 30 PSW staff on the day shift; 2 RNs, 8 RPNs and 24 PSW staff on the evening shift; and total of 4 registered staff ensuring at least 1 RN and 9 PSW staff on the night shift.

The home had a reduced occupancy, with approximately 50 vacant beds, in the spring of 2021, when a decision was made that the nursing department was able to be staffed with a reduced complement of PSW hours.
Written direction identified that PSW shifts were to be filled without going into overtime, unless the home was greater than 6 unfilled PSW shifts on the day shift or 4 unfilled PSW shifts on the evening shift.
Unfilled RPN shifts were to be replaced with another RPN unless this required overtime at which time the RN would take over the RPN assigned duties on the day and evening shifts, in addition to their regular assignment.
On the night shift if there was an unfilled RPN shift, 1 of the RNs was to take over the assigned RPN duties and if there were 2 unfilled RPN shifts then the RN was to complete RPN duties and overtime could be utilized or agency staff.

Records provided by the home identified that their occupancy level increased in the summer of 2021 with 190 residents in June 2021, 199 residents in July 2021 and 203 residents in August 2021.
At the time of the inspection the targeted occupancy was 200 residents and this was achieved and maintained with admissions.
The reduced staffing direction provided in the spring of 2021 had not changed when the resident occupancy increased, as confirmed by the staff.
The home continued to replace shifts at the reduced staff complement despite an increase in the number of residents in the home.
The home did provide cross training to non-nursing staff to allow them to assist in situations of nursing staff shortages in areas such as feeding, spotting for lifts and transfers and other tasks.
The home increased their complement of staff in a department and included the distribution of nourishments into their job routines on specific shifts, a task previously completed by PSW staff.
The home provided written direction to utilize in situations of working below the desired staffing complement as an overview of the care needs of each resident home area to assist in reassigning staff, as needed.

A request was made to review 28 specific dates, a sampling of the Daily Staffing Reports, over a time frame of 15 weeks for staffing levels and mix.
i. The sampling identified that the home worked both below their planned PSW staffing as set out in the Daily Staffing Report and their reduced staffing complement, on a number of day, evening and night shifts, during the identified time period.
There were 11 occasions where there were 23 or less PSW staff on the day shift;

an occasion where there was only 10 PSWs on the evening shift; and six occasions where there were 7 or less PSWs on the night shift.
ii. The sampling identified that the number of RPNs working, was below the desired staffing complement on 35 occasions, including on one occasion when there was only 5 RPNs in the home on the day shift until 1030 hours, and on a second occasion when there were 6 RPNs on the evening shift.
iii. The sampling identified eight occasions where there was only 1 RN in the home on the day or evening shift. Additionally, it was identified that on two occasions there were only 3 registered staff in the home on the night shift.

Management staff reported that a "Critical Issues Meeting" was held in August 2021, to review staffing/occupancy. At this time there were no changes made to the staffing complement and they continued to work, without offering overtime unless they were up to 6 unfilled PSW shifts on the day shift and up to 4 unfilled PSW shifts on the evening shift.

Resident Council Meeting Minutes for August 2021, included that some floors did not receive bedtime nourishment consistently; and identified the current occupancy was 207 residents.
Resident Council Meeting Minutes, for September 2021, included the occupancy was 202 residents and that new admissions were on hold until January 2022, to ensure staffing levels were sufficient for resident occupancy, a nursing staffing plan was developed to recruit/retain additional staff and a plan was developed to address resident care.
Resident Council Meeting Minutes, for October 2021, included that a resident home area had only one regular staff and two students who worked one evening and residents felt like they were imposing if they rang their call bell.

Family Council Meeting Minutes, in October 2021, included a discussion related to staffing concerns.

During this inspection areas of non-compliance were identified which supported that the staffing mix was not consistent with residents' assessed care and safety needs, including:

A. Unsafe transferring or positioning of residents:
i. The plan of care identified that the resident required assistance with two staff and a device for transfers.
Interviews with two staff confirmed awareness of recent occasions where staff

transferred the resident with one staff and the device without incident, despite the directions in the plan of care due to insufficient staffing.

ii. A staff was observed to use a device to transfer a resident from one position to another. The staff was also observed to leave the resident with the device in place when they left the room and walked down the hall, for a few moments.
A review of the resident's plan of care identified that they required assistance with two staff and a device for transfers as confirmed by staff.
The staff identified they were unaware the resident required two people for the transfer as they were reassigned from another resident home area, in the middle of the shift as they were short staffed.

B. Failure to complete scheduled bathing or to complete bathing by the resident's method of choice:
i. A resident was identified in their plan of care to require assistance with bathing.
According to the resident they were not bathed on two occasions.
A review of the Point Of Care (POC) Follow Up Questions Report for bathing for two months, supported that the resident missed baths and that they received a bed bath on two dates, which was not their preference.
According to statements and documentation, bathing was not provided twice a week or by their preferred method.

ii. A complaint received by the MOLTC specifically identified a resident was not bathed as required.
The resident was identified on the bath list for bathing twice a week and the plan of care noted staff assistance.
A review of the POC Follow Up Questions Report for bathing for a month, noted that the resident was bathed five times out of nine scheduled baths.
Staff identified that it was presumed that the resident was not bathed twice a week, due to a lack of documentation.

iii. The Resident/Family Questionnaire completed on admission identified that a resident's previous routine was a tub bath.
A review of the POC Follow Up Questions Report for bathing for 25 consecutive days included that they received five showers and three bed baths during the identified time period.
According to documentation, bathing was not provided in accordance with their preferences.

iv. A resident voiced a concern related to bathing.
Discussion with the resident noted that at the time of the complaint they had already missed one bath that month and had previously missed baths in the past.
A review of the POC Follow Up Questions Report for bathing for two months, noted that the resident had not been provided nor refused bathing in accordance with the bathing schedule on two dates in the time frame.

v. A resident was identified on the bath list for bathing twice a week.
A review of the POC Follow Up Questions Report for bathing for 24 consecutive days noted that the resident was not bathed on two occasions as scheduled.
It was identified that it was presumed that the resident was not bathed twice a week, due to a lack of documentation.

vi. The Resident/Family Questionnaire completed on admission identified that a resident preferred tub baths.
The resident was not able to answer questions at the time of the inspection related to bathing.
A review of the POC Follow Up Questions Report for bathing for 25 consecutive days included that they received one bath, two showers and five bed baths during the identified time period.
According to staff statements and documentation, bathing was not provided in accordance with their preference.

Discussion with a staff member who was routinely assigned to complete baths identified that bed baths were frequently completed when the home was short staffed; however, efforts were made to ensure that residents did not receive two bed baths in a row unless that was their preference as noted in the plan.

C. Failure to provide care as set out in the plan of care:
The plan of care for a resident identified that they had a routine after breakfast daily.
i. A progress note included that the family was upset as they found the resident in a location, not consistent with their routine and felt it was due to staff shortage.
Interview with staff confirmed that the plan of care was not followed; that the resident's home area was short staffed and the staff did not follow the resident's routine after breakfast on the identified date.
On a second date the resident was found in a location, not consistent with their routine after breakfast.
Interview with staff confirmed that the plan of care was not followed as the

resident's routine was not followed after breakfast.

ii. The plan of care for a resident identified that they would be toileted at a specific time as a fall prevention strategy.
Staff wrote a progress note which included that staff did not toilet the resident related to short staffing on the shift.
The staff confirmed that the plan of care was not followed as the home was short staffed on the identified shift.

iii. A review of the plan of care for a resident included to turn and reposition every two hours while awake and every four hours (when in bed) to prevent skin breakdown and promote sleep.
The resident was observed in bed, dressed in street clothing at 1825 hours and additional observations during the shift noted no changes in their position.
After 2200 hours, staff confirmed that for a period of time greater than three and a half hours the resident did not receive care and that the staff had worked short on the identified shift.
Care was not provided as set out in the plan of care related to positioning.

D. Failure to ensure that residents were dressed suitable for the time of day:
Three residents were observed on a resident home area to be dressed in their sleepwear at 1530 hours.
The plans of care for each resident noted that they would be appropriately dressed and did not identify that they preferred to be dressed in sleepwear prior to the evening meal.
Staff identified that the practice of dressing specified residents in their bedtime clothing early in the afternoon was initiated to assist when there were staffing concerns to ensure that care was being completed.

E. Failure to reposition a resident as required:
A resident was observed being put to bed at 1745 hours.
No additional care or repositioning was provided to the resident between 1745 hours and 2215 hours, as confirmed by staff.
Staff also reported that they worked short on the identified shift.
The resident had a plan of care that identified they were dependent on staff for repositioning and were at risk for skin breakdown.
Staff confirmed that the resident should have been repositioned every two hours and the risk of not being repositioned every two hours was the potential for skin breakdown.

F. Failure to offer or provide beverages at the frequency of three between meal beverages:
i. A complaint was received that the morning beverages were not offered or served in a specific resident home area over the course of four specific dates, due to staffing issues.
A review of POC records for the amount of fluids taken at nourishment for three residents identified that they had not been completed for the morning beverage nourishment.
Interview with staff confirmed that morning beverages were not offered or served on the identified dates in the home area.

ii. A staff confirmed that they had not completed the morning beverage nourishment on a specific date due to staffing issues on a resident home area.
A review of POC records for the amount of fluids taken at nourishment for three residents identified that the records had not been completed for the morning beverage nourishment.

iii. A review of POC records for the amount of fluids taken at nourishment for three resident had been left blank for the morning beverage nourishment on a specific date in a resident home area.
Staff confirmed that only residents with labelled nourishments received morning beverages on that day due to the staffing shortages.

G. Failure to serve the evening meal until at least 1700 hours:
i. A staff member reported that residents on a modified diet were served their meal prior to 1700 hours.

ii. At 1630 hours approximately 12 residents were seated and served their modified diet meal in a dining room of a resident home area.
Staff identified the routine to serve residents on a modified diet prior to 1700 hours, was initiated during the COVID-19 pandemic and continued due to staffing shortages, as this allowed staff to assist the residents prior to meal service for all residents.

iii. At 1640 hours five residents were served their modified diet meal in a dining room and at 1651 hours three additional residents were served their modified diet meal.
Staff identified that the routine to serve residents on a modified diet prior to 1700

hours was in place due to staffing shortages and allowed staff to assist the residents prior to the meal service for all other residents.

H. Failure to serve meals course by course:
Observation of a meal in a dining room identified that residents had not completed their entrée when the dessert had already been served.
Staff confirmed that the residents were not served course by course and verified the routine of serving dessert while the entrée was still being consumed was not in the resident's plans of care nor indicated by their assessed needs.
Staff reported that they worked short on the shift that the meal was observed.

Additionally, concerns were raised related to staff response time to the communication and response system.
A review of call bell logs for a resident noted that:
i. On a day shift there was an occasion where it took approximately 10 minutes for staff to cancel the alarm.
ii. On another day shift there were two occasions where it took approximately 10 minutes for staff to cancel the alarm.
iii. On an evening shift there were two occasions where it took staff over 25 minutes to cancel the alarm, one occasion where it took over 15 minutes to cancel the alarm and one occasion where it took approximately 10 minutes to cancel the alarm. A progress note identified concerns from the resident's family, on this shift, regarding the length of time it took for staff to respond to the call bell.
iv. On a second evening shift there was an occasion where it took staff over 25 minutes to cancel the alarm.

The home reported that they currently had 3 full time and 30 part time PSW positions to be filled; 2 full time and 5 part time RPN positions to be filled; and 4 part time RN positions to be filled. It was identified that the home had staff who would not be able to work in the home due to COVID-19 vaccination status.

In an effort to fill vacant nursing department shifts the home had established relationships with five staffing agencies.

It was identified that the home had or were in the process of implementing some strategies which would assist in the retention of some current nursing staff.

Following a discussion during the inspection it was identified that the exact date that the written direction related to reduced PSW staffing levels and offering of

overtime was unknown as was the author of the written direction which was provided in the spring of 2021.
During the inspection a decision was made that effective immediately the home would attempt to replace all unfilled shifts as needed to achieve the staffing plan as set out in the Daily Staffing Report, with the exception of 3 PSW shifts on the day shift.

The staffing plan did not provide for a staff mix that was consistent with residents' assessed care and safety needs which resulted in risk of harm to residents in the home; when they failed to reevaluate staffing levels when there was an increase in the number of residents in the home. This resulted in unmet or a delay in meeting resident care needs.

Sources: Observations of the provision of care and services, a review of clinical health records; Daily Staffing Reports; meeting minutes; call bell logs and bathing schedules and interviews with residents and family members and staff. [s. 31. (3)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's right to receive visitors of their choice was fully respected and promoted.

A resident's clinical record identified that a family member was denied entry into the home to visit the resident one evening at 1930 hours.
The family member identified that they wanted to assist the resident with care and had communicated to the resident they would be in for a visit.
The staff member confirmed that they did not allow the visitor into the home as the time was after visiting hours which were from 0700 hours until 1900 hours according to a memo and because the screener was off shift and the staff was too busy to screen the visitor.
Management said that they were unaware that the family was restricted from visiting and that visitors were not restricted from the home. Following a review of the memo, the management identified that it was their opinion that the staff member misunderstood the intent of the memo.

Failure to allow the resident's family to visit did not respect or promote the resident's rights.

Sources: A resident's clinical record, Point Click Care memo and interviews with staff. [s. 3. (1) 14.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident's right to receive visitors of their choice is fully respected and promoted, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. A. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the residents.

The MOLTC received complaints that residents were not able to go to bed at their desired bedtime due to the lack of staff available.
The care plans for two residents did not include a desired bedtime, as confirmed by staff.
Both residents had quarterly progress notes which identified their desired bedtime.
Staff confirmed the plan should include a desired bedtime if their preference was known.
The planned care for the residents was known and included in the progress notes; however, was not set out in the plans of care which all staff were able to access.

Failure to include the planned care for a resident in the plan of care increased the possibility that they were not cared for in accordance with their preferences.

Sources: Observations of residents during the evening shift and a review of the progress notes and care plans and interviews with staff.

B. The licensee failed to ensure that the written plan of care for a resident set out the planned care for a resident.

A resident had a history of falls and sustained falls.
A progress note identified that following falls the resident's family member voiced concerns and spoke with staff regarding pain management and falls prevention.

The staff documented that they would put a note to direct staff to offer the resident as needed pain medication for the next few days in response to the concern of pain management.
Additionally, the record noted that interventions were put into place for falls management which included direction for staff to remind the resident to use a device.
A review of the electronic Medication Administration Record (eMAR) and progress notes did not include that any additional pain medication was offered, administered or refused during the time frame.
Staff who worked with the resident could not recall a note to offer the resident pain medication; however, noted that the resident denied and did not demonstrate any non verbal signs of pain.

A review of the plan of care did not include direction for staff to remind the resident to use a device.
Staff following a review of the notes, eMAR and plan confirmed that the planned care was not included in the resident's plan of care related to offering pain medication or reminders to use the device.
The planned care for the resident was included in the progress notes; however, was not set out in other areas of the plan of care for staff to access.

Failure to ensure that the plan of care included the planned care for the resident had the potential to increase the risk of falls and unmanaged pain.

Sources: A review of the progress notes and plan of care for a resident and interviews with staff. [s. 6. (1) (a)]

2. A. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

i. According to the plan of care a resident walked with a mobility device and walked with supervision without mention of a mobility device.
Observations of the resident included that they walked with a device at all times.
The plan of care did not provide clear direction related to the use of the device and that it should be in the resident's reach at all times.
The resident sustained a fall when their device was out of reach.
Interview with staff confirmed that the plans of care should be specific to each resident's care needs including the use of mobility devices.
The plan of care did not provide clear direction to staff who provided care.

ii. A resident's progress notes and assessments noted that they had a custom device and used an attachment on their mobility aid.
The plan of care did not provide direction related to the device or how to use it nor the attachment to their mobility aid.
Additionally, the resident had communicated specific preferences to staff related to placement of communication tools to allow for independence and accessibility as identified by staff.
There was no direction in the plan of care related to the placement of these items to allow for safe and independent use.

Failure to ensure that the plans of care provided clear direction to staff who provided care to the residents had the potential to result in resident frustration and

unmet or delayed care needs.

Sources: Plans of care for residents, resident observations and interviews with staff.

B. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the residents.

The MOLTC received complaints that residents did not have their continence care needs consistently met due to the lack of staff available.
According to their plans of care three residents required assistance of staff for toileting or to meet their continence care needs. Although the plans provided direction regarding the level of assistance required there was no direction as to the frequency of the provision of care.
The plans of care did not provide clear direction to staff who provided care.

Staff confirmed that the plans of care should be specific to each resident's care needs including in the frequency of toileting or continence care needs.

Failure to ensure that the plans of care provided clear direction had the potential to result in residents not being afforded care in accordance with assessed needs.

Sources: Review of the plans of care for residents, observations of the residents and interviews with staff. [s. 6. (1) (c)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of a resident so that their assessments were integrated, consistent with and complemented each other.

A resident sustained three falls in a quarter.
A review of two of the post fall assessments completed in the quarter noted that the resident did not have a history of falls in the past three months.
A review of the Resident Assessment Protocol (RAP) dated immediately following the quarter, noted that the resident sustained three falls in the past 180 days.
Staff who completed the post fall assessment at the time of one of the falls confirmed that the document incorrectly noted that there was no falls history.

There was potential risk to the resident that they might not have been assessed

appropriately for additional fall prevention interventions, when the post fall assessments were not integrated and consistent with each.

Sources: A review of the post fall assessments and RAPs for a resident and interviews with staff. [s. 6. (4) (a)]

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

The plan of care for a resident included that they were not to be left unattended on the toilet.
The resident was observed in their room with staff and staff exited the room with the resident in the room and closed the door.
The staff confirmed that the resident was on the toilet, unattended.
The resident was not provided care as per the plan of care when they were left unattended on the toilet.

There was a risk of potential falls to the resident when the staff left them unattended on the toilet.

Sources: Plan of care for a resident, observations of care and interviews with staff.

B. The licensee failed to ensure that the care was provided to a resident as specified in their plan of care.

The plan of care for a resident identified that they had a routine after breakfast daily.
i. A progress note included that the family was upset as they found the resident in a location, not consistent with their routine and felt it was due to staff shortage.
Interview with staff confirmed that the plan of care was not followed; that the resident's home area was short staffed and the staff did not follow the resident's routine after breakfast on the identified date.
On a second date the resident was found in a location, not consistent with their routine after breakfast.
Interview with staff confirmed that the plan of care was not followed as the resident's routine was not followed after breakfast.

The risk to the resident was insufficient time in an activity.

Sources: A resident's clinical record, observation of the resident and interviews with staff.

ii. The plan of care for a resident identified that they would be toileted at a specific time as a fall prevention strategy.
Staff wrote a progress note which included that staff did not toilet the resident related to short staffing on the shift.
The staff confirmed that the plan of care was not followed as the home was short staffed on the identified shift.

The risk to the resident was that the falls prevention strategy was not followed and the resident could have attempted to self transfer to the toilet.

Sources: Resident's clinical record and interview with staff.

C. The licensee failed to ensure that a resident was provided care as set out in the plan of care related to positioning.
A review of the plan of care for a resident included to turn and reposition every two hours while awake and every four hours (when in bed) to prevent skin breakdown and promote sleep.
The resident was observed in bed, dressed in street clothing at 1825 hours and additional observations during the shift noted no changes in their position.
After 2200 hours, staff confirmed that for a period of time greater than three and a half hours the resident did not receive care and that the staff had worked short on the identified shift.
Care was not provided as set out in the plan of care related to positioning.

Failure to provide care as set out in the plan of care put the resident at risk related to falls prevention and skin and wound care management.

Sources: Observations of a resident and a review of their plan of care and interviews with staff.

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

A resident was on a physiotherapy program which included services at a set frequency each week, as set out in their plan of care.

A review of their progress notes identified that during a seven week period of time they were not consistently offered/provided therapy at the planned frequency each week, on five occasions due to insufficient staffing.
Interview with staff confirmed that the resident did not receive PT services at the frequency as set out in the plan of care, due to staffing shortages.

Failure to provide therapy as set out in the plan of care had the potential to negatively impact the resident in achieving their goals.

Sources: Plan of care and progress notes for a resident and interview with staff. [s. 6. (7)]

5. A. The licensee failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A resident was at risk of falls and had a history of falling.
A review of their plan of care noted the risk of falls and included an intervention; however, did not include the use of a second intervention which was observed to be in place.
Observations of the resident and their environment included the second intervention; however, the first intervention was not in use.
Staff confirmed that the resident's plan of care was not revised when their care needs changed related to their falls prevention interventions.

Failure to revise the resident's plan of care to reflect changes in their care needs and when care set out in the plan of care was no longer necessary, had the potential for risk, if staff were not aware of the resident's current care needs and as a result care was not provided as required.

Sources: Plan of care and records of a resident, observations of the resident and interviews with staff.

B. The licensee failed to ensure that the plan of care for a resident was revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A resident sustained an injury, had a change in condition, required the use of a mobility device and were dependent on staff and a device for transfers.

A review of their plan of care included that the resident required a device for transfers and that they were dependent on a mobility device.
Interviews with the resident and two staff and observations confirmed that the resident no longer utilized the identified mobility device, was mobile and did not require a device during transfers.
The plan of care was not revised with changes in the resident's care needs or when care set out in the plan was no longer necessary.

Failure to revise the resident's plan of care to reflect changes in their care needs and when care set out in the plan of care was no longer necessary, had the potential for risk, if staff were not aware of the resident's current care needs and as a result care was not provided as required.

Sources: Clinical health record and plan of care for a resident, observations and interviews with the resident and staff. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident; that staff and others involved in the different aspects of care collaborated with each other in the assessment of residents so that their assessments are integrated, consistent with and complement each other; to ensure that the care set out in the plan of care is provided to residents as set out in the plan; and that plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a 24-hour admission care plan was developed for a resident and communicated to direct care staff within 24 hours of admission regarding any risk of falling and interventions to mitigate those risks.

Every resident was to have an admission care plan developed and communicated to direct care staff within 24 hours of the resident's admission to the home.
A resident was admitted to the home and a progress note identified that they demonstrated behaviours which increased their risk of falls.
An admission falls assessment completed identified they were at risk for falls and included interventions; however, a 24-hour care plan was not developed related to falls.
The initial care plan was not in place for the resident related to falls until approximately two weeks later, following a fall, as confirmed by staff.

As a result of the resident's 24-hour plan not including their risk of falling or interventions to mitigate falls, the resident might have been at increased risk for injury, as staff might have been unaware of the resident's risk and fall prevention interventions.

Sources: Clinical record for a resident including care plan and falls assessments and interviews with staff. [s. 24. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a 24-hour admission care plan is developed for residents and communicated to direct care staff within 24 hours of admission regarding any risk of falling and interventions to mitigate those risks, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The MOLTC received complaints that when the home worked below their desired staffing complement, residents were not bathed as required.
i. A resident was identified in their plan of care to require assistance with bathing. According to the resident they were not bathed on two occasions.
A review of the Point Of Care (POC) Follow Up Questions Report for bathing for two months, supported that the resident missed baths and that they received a bed bath on two dates, which was not their preference.
According to statements and documentation, bathing was not provided twice a week or by their preferred method.

ii. A complaint received by the MOLTC specifically identified a resident was not bathed as required.
The resident was identified on the bath list for bathing twice a week and the plan of care noted staff assistance.
A review of the POC Follow Up Questions Report for bathing for a month, noted

that the resident was bathed five times out of nine scheduled baths.
Staff identified that it was presumed that the resident was not bathed twice a week, due to a lack of documentation.

iii. The Resident/Family Questionnaire completed on admission identified that a resident's previous routine was a tub bath.
A review of the POC Follow Up Questions Report for bathing for 25 consecutive days included that they received five showers and three bed baths during the identified time period.
According to documentation, bathing was not provided in accordance with their preferences.

iv. A resident voiced a concern related to bathing.
Discussion with the resident noted that at the time of the complaint they had already missed one bath that month and had previously missed baths in the past.
A review of the POC Follow Up Questions Report for bathing for two months, noted that the resident had not been provided nor refused bathing in accordance with the bathing schedule on two dates in the time frame.

v. A resident was identified on the bath list for bathing twice a week.
A review of the POC Follow Up Questions Report for bathing for 24 consecutive days noted that the resident was not bathed on two occasions as scheduled.
It was identified that it was presumed that the resident was not bathed twice a week, due to a lack of documentation.

vi. The Resident/Family Questionnaire completed on admission identified that a resident preferred tub baths.
The resident was not able to answer questions at the time of the inspection related to bathing.
A review of the POC Follow Up Questions Report for bathing for 25 consecutive days included that they received one bath, two showers and five bed baths during the identified time period.
According to staff statements and documentation, bathing was not provided in accordance with their preference.

Discussion with a staff member who was routinely assigned to complete baths identified that bed baths were frequently completed when the home was short staffed; however, efforts were made to ensure that residents did not receive two bed baths in a row unless that was their preference as noted in the plan.

Failure to bath residents twice a week or by a method of their choice had the potential to negatively impact their hygiene.

Sources: Care plans, POC records, bath schedules and Questionnaires for identified residents and interviews with staff. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are bathed at a minimum of twice a week and by a method of their choice, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

The MOLTC received complaints that staff had transferred residents in a way that was inconsistent with their care needs, which included a specific resident due to the staffing levels available during the provision of care.
i. The plan of care identified that the resident required assistance with two staff and a device for transfers.
Interviews with two staff confirmed awareness of recent occasions where staff transferred the resident with one staff and the device without incident, despite the directions in the plan of care due to insufficient staffing.

ii. A staff was observed to use a device to transfer a resident from one position to another. The staff was also observed to leave the resident with the device in place when they left the room and walked down the hall, for a few moments.
A review of the resident's plan of care identified that they required assistance with two staff and a device for transfers as confirmed by staff.
The staff identified they were unaware the resident required two people for the transfer as they were reassigned from another resident home area, in the middle of the shift as they were short staffed. (#506)

Failure to transfer residents in accordance with their assessed needs/abilities had the potential to result in injuries to the residents.

Sources: Plans of care of residents, observations of care for a resident and staff interviews. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning techniques, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that three resident were dressed appropriately, suitable to the time of day and in keeping with their preferences.

Three residents were observed on a resident home area to be dressed in their sleepwear at 1530 hours.
The plans of care for each resident noted that they would be appropriately dressed and did not identify that they preferred to be dressed in sleepwear prior to the evening meal.
Staff identified that the practice of dressing specified residents in their bedtime clothing early in the afternoon was initiated to assist when there were staffing concerns to ensure that care was being completed.

Sources: Clinical records for the residents, observation of the residents and interviews with staff. [s. 40.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are dressed appropriately, suitable to the time of day and in keeping with their preferences, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required.

A resident was observed being put to bed at 1745 hours.
No additional care or repositioning was provided to the resident between 1745 hours and 2215 hours, as confirmed by staff.
Staff also reported that they worked short on the identified shift.
The resident had a plan of care that identified they were dependent on staff for repositioning and were at risk for skin breakdown.
Staff confirmed that the resident should have been repositioned every two hours and the risk of not being repositioned every two hours was the potential for skin breakdown.

Sources: Observation of a resident and a review of their clinical record and interviews with staff. [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who are dependent on staff for repositioning are repositioned every two hours or more frequently as required, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a minimum of, a between-meal beverage in the morning and after dinner.

The MOLTC received complaints that residents were not consistently offered or served between meal beverages due to the lack of staffing.

i. A complaint was received that the morning beverages were not offered or

served in a specific resident home area over the course of four specific dates, due to staffing issues.
A review of POC records for the amount of fluids taken at nourishment for three residents identified that they had not been completed for the morning beverage nourishment.
Interview with staff confirmed that morning beverages were not offered or served on the identified dates in the home area. (#506)

ii. A staff confirmed that they had not completed the morning beverage nourishment on a specific date due to staffing issues on a resident home area.
A review of POC records for the amount of fluids taken at nourishment for three residents identified that the records had not been completed for the morning beverage nourishment. (#506)

iii. A review of POC records for the amount of fluids taken at nourishment for three resident had been left blank for the morning beverage nourishment on a specific date in a resident home area.
Staff confirmed that only residents with labelled nourishments received morning beverages on that day due to the staffing shortages.

iv. Observations of a portion of the evening nourishment pass was completed on a resident home area.
Beverages were not offered or provided to four residents as they were either sleeping in chairs in the lounge or in their beds.
The POC records for the amount of nourishment taken for each of the residents for the evening pass noted that the residents were not available.
The staff indicated that they did not offer or serve beverages to residents who were sleeping at the time of distribution.

Failure to provide residents with a between meal beverage had the potential that the resident did not meet their hydration goals.

Sources: POC nourishment records and interviews with staff. [s. 71. (3) (b)]

2. The licensee failed to ensure that all residents were offered a minimum of a snack in the evening.

The MOLTC received complaints that not all resident's received their nourishment when the home worked below their desired staffing complement.

A a portion of the evening nourishment pass was observed on a resident home area.
Snacks were not provided or offered to four residents as the residents were either sleeping in chairs the lounge or in their beds.
The POC records for snack for each of the residents for the evening pass noted resident sleeping.
The staff indicated that they did not offer or serve snacks to residents who were sleeping at the time of distribution.

Failure to offer residents a minimum of a snack in the evening had the potential to negatively impact their nutrition.

Sources: Observations of the nourishment pass, review POC records of the identified residents and interview with staff. [s. 71. (3) (c)]

3. The licensee failed to ensure that the evening meal was not served before 5:00 p.m.

i. A staff member reported that residents on a modified diet were served their meal prior to 1700 hours.

ii. At 1630 hours approximately 12 residents were seated and served their modified diet meal in a dining room in a resident home area.
Staff identified the routine to serve residents on a modified diet prior to 1700 hours, was initiated during the COVID-19 pandemic and continued due to staffing shortages, as this allowed staff to assist the residents prior to meal service for all residents. (#506)

iii. At 1640 hours five residents were served their modified diet meal in a dining room and at 1651 hours three additional residents were served their modified diet meal.
Staff identified that the routine to serve residents on a modified diet prior to 1700 hours was in place due to staffing shortages and allowed staff to assist the residents prior to the meal service for all other residents.

Serving the evening meal prior to 1700 hours had the potential to shortened or extended times between nourishment for residents and impact their nutritional status.

Sources: Observations of the evening meal in the dining rooms and interviews with staff. [s. 71. (6)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is offered a minimum of, a between-meal beverage in the morning and after dinner and a snack in the evening, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) 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; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that for every complaint 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; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made by the complainant.

i. Complaints were received, by the MOLTC, related to the bathing of residents.
A review of the complaints binder included a complaint that a resident had not been consistently bathed.
The documented complaint included the concern and that a shower was provided the day that the complaint was received.
The record did not include actions taken to resolve the complaint related to ongoing bathing activities; any follow-up action required; the final resolution; the response provided to the complainant nor the complainant's response.

It was confirmed that the complaint record was not complete.

Sources: Review of complaints binder, Note to File and interviews with staff.

ii. A review of a resident's clinical record identified that the family had concerns regarding the resident's falls.
There was documentation that the family was not satisfied with the response they received from a staff member and was directed to speak with a manager of the home.
The manager confirmed that they had spoken to the family and referred them to another staff member for follow-up.
A review of the complaints binder did not include a documented record regarding the nature of the complaint, actions taken to resolve the complaint; any follow-up action nor the final resolution and any responses provided.
It was confirmed that the complaint record was not complete.

Sources: Review of complaints binder, progress notes for a resident and interviews with staff. (#506)

iii. A review of the progress notes for a resident included a family concern.
The documentation was related to a number of concerns expressed by the family including concerns related to the dietary and nursing departments.
It was identified that the resident was recently readmitted from the hospital and that a reassessment of the resident was currently in process at the time of the complaint and that this would capture any changes to the resident's care needs.
There was no documentation of the type of action taken to resolve the complaint, the final resolution or any response made to or by the complainant related to the concerns.
A review of the complaints binder did not include any record of the complaint.

Sources: Review of complaints binder, progress notes related to a resident and interview with staff.

Failure to maintain a record of complaints as required increased the potential for additional complaints and inconsistent actions to resolve concerns. [s. 101. (2)]

2. The licensee failed to ensure that there was a documented record, of complaints received, which was reviewed and analyzed for trends, at least quarterly to be taken into account when determining what improvements were

required in the home.

A request was made of staff for the complaints log and the quarterly review and analysis for two quarters.
It was confirmed that the home did not maintain a complaints log.
It was identified that there was a plan to complete a quarterly review of complaints; however, it had not been implemented and that there was no formal or written process in place for the quarterly review of complaints to analyze for trends and to assist in determining improvements in the home.

Sources: Interviews with staff. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for every complaint which is not resolved within 24 hours a documented record is kept in the home that includes the type of action to take to resolve the complaint; including the date of the action; time frames for actions; any follow-up action required; the final resolution, if any; every date on which any response is provided to the complainant and a description of the response; and any response made by the complainant, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. A. The licensee failed to ensure that all staff participated in the implementation of the infection and prevention and control program (IPAC) related to hand hygiene.

It was identified that the home followed Routine Practices and Additional Precautions, In All Health Care Settings,which included links to Ontario's evidenced based Just Clean Your Hands, hand hygiene improvement program and Provincial Infectious Diseases Advisory Committee Best Practices for Hand Hygiene in All Health Care Settings. These documents identified that hand hygiene was to be completed by residents and staff.

i. During a meal a staff member was observed to assist four residents with feeding without completing hand hygiene.
The staff did not wash their hands between assisting the four residents, which they confirmed. (#506)

ii. During a nourishment observation two staff members were observed to serve four residents a beverage without immediate prior assistance with hand hygiene. (#506)

iii. On two occasions nourishment passes were observed.
During the observation two different staff were observed to serve nourishment and touch soiled items without preforming hand hygiene.
The staff also failed to provide residents with immediate prior assistance with hand hygiene.
The staff confirmed that they had received training on hand hygiene and there was alcohol based hand rub on the nourishment cart for use.

Failure to comply with the home's hand hygiene program might have increased the risk to residents related to the possible ingestion of disease-causing organisms that might have been on their hands.

Sources: Observations of meals and nourishment passes, review of Routine Practices and Additional Precautions, In All Health Care Settings, and interviews with staff.

B. The licensee failed to ensure that all staff participated in the implementation of the infection and prevention and control program related to the use of best

practices.

It was identified that the home followed Routine Practices and Additional Precautions, In All Health Care Settings, which included direction related to the use of the basic elements of Routine Practices including the use of barriers, such as the use of plexiglass as an environmental control and the appropriate use of Personal Protective Equipment (PPE).

i. Directive #5 provided direction related to required precautions and procedures, which included that individuals who were responsible for screening were to wear appropriate PPE that protected their eyes, nose and mouth, if they were required to be within two metres of another person who did not have a mask or face covering, when in an indoor area, and not separated by plexiglass or some other impermeable barrier.
Observations of a staff member who was responsible to screen others included that they were not wearing eye protection nor were they behind plexiglass when they were screening and provided visitors and staff with surgical masks on entry to the home.
Following a discussion with the DOC plexiglass was put in place where the staff member was located.
Observations of staff noted that although plexiglass was in place they greeted individuals, who had not been screened and provided them with a new surgical mask to be donned, away from the protection of the plexigalss.
Public Health confirmed the expectation that staff PPE included eye protection when plexiglass was not in place and the staff were within two meters of those entering the home.

Sources: CMOH's Directive #5 and Public Health Ontario, Technical Brief, IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspected or Confirmed COVID-19, observations and interviews with staff.

ii. Not all staff complied with universal masking requirements when a double mask was worn.
Observations included that two staff were double masked when in the home.
Management staff, including the infection prevention and control (IPAC) lead, identified that they were unaware that the staff were double masked and confirmed that this use of PPE did not comply with universal masking procedures.
Public Health staff confirmed that double masking did not comply with universal

masking procedures as per the Chief Medical Officer of Health (CMOH)'s Directive #3.

Sources: Observations and interviews with staff. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written procedure that complied with the regulations for initiating complaints to the licensee and for how the licensee dealt with complaints.

A review of the home's complaints binder and interview with staff identified that there were concerns regarding how the home dealt with complaints and/or concerns regarding care and services.
A request was made for the home's policy and procedure for dealing with and managing complaints.
The staff were not able to locate or provide a complaints policy or procedure and it was confirmed that the home did not have a policy or complaints procedure.

Sources: Complaints binder and interviews with staff. [s. 21.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under the falls prevention and management program as required in O. Reg 79/10 s. 48 including assessments, interventions and the resident's response to interventions were documented.

According to the plan of care a resident was at risk of falls.
The resident sustained falls.
i. The resident consented to the use of a falls management intervention.
A review of their POC documentation related to the specific intervention was responded to as "not applicable" on specific dates during a time frame.
Staff confirmed that the resident used the intervention due to a falls risk and that the intervention was in place on an identified date, during their shift.
The intervention was not documented as required.

Sources: Clinical record of a resident, including progress notes, kardex, plan of care and POC documentation and interviews with staff.

ii. It was identified that new interventions should be trialled after a fall, unless there were no additional interventions to implement or if the resident refused, in which case the assessment of the staff or resident's response would be documented.
Following a resident sustaining falls on two occasions, there were no immediate changes made to the resident's plan of care related to falls prevention and management.
The post fall assessments completed for both falls noted that the plan was edited.
On review of the plan of care there were no additional interventions immediately implemented or other changes made to the plan related to falls prevention and management.
Staff who worked when one of the falls occurred, confirmed that the plan of care was not revised, based on their assessment and the resident's decision making.
There was no documentation to support the assessment findings of the staff to indicate that no additional interventions were required, nor was the resident's response documented.

Sources: Clinical record of a resident, including kardex, plan of care and post fall assessments and interviews with staff. [s. 30. (2)]

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

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the daily menu was communicated to residents on a modified diet.

The daily menu was posted as orange marmalade pork loin, roast potatoes and glazed parsnips or brown sugar chicken thighs, mashed potatoes and steamed spinach.
Residents on a modified diet were offered a choice of chicken, macaroni and tomatoes or pork, green beans and potato.
The modified menu was not communicated to residents when it was not posted.

A family member was overheard to ask staff about the meal served to the resident on a modified diet. The staff was not able to answer the question of the family member based on the menu posted.

The daily menu was not communicated to all residents.

Sources: Observations of the meal, review of the posted menu and interviews with staff. [s. 73. (1) 1.]

2. The licensee failed to ensure that beverages served at a meal were served at a temperature that was palatable to the residents.

Observation of a meal in a dining room identified that the beverages were on the tables for all residents at 1630 hours and most residents did not have their meal until 1730 hours.
At 1650 hours the milk was probed by the Inspector at 17 degrees Celsius (C); at 1715 hours the milk was probed at 19 degrees C; and at 1730 hours the milk was probed at 20.9 degrees C.
A resident identified that in their opinion the milk was lukewarm.
Staff confirmed that they served the beverages at the same time for all residents, to accommodate those on pureed textured diet to be served around 1630 hours.

Sources: Observation of the dining room and interviews. [s. 73. (1) 6.]

3. The licensee failed to ensure that residents were provided their meals course by course.

Observation of a meal in a dining room identified that residents had not completed their entrée when the dessert had already been served.
Staff confirmed that the residents were not served course by course and verified the routine of serving dessert while the entrée was still being consumed was not in the resident's plans of care nor indicated by their assessed needs.
Staff reported that they worked short on the shift that the meal was observed.

Sources: Observation of the dining room and interview with staff. [s. 73. (1) 8.]

Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

Issued on this 14th day of January, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LISA VINK (168) - (A1)
Inspection No. / No de l'inspection :	2021_916168_0011 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	010632-21, 011701-21, 011762-21, 012519-21, 012800-21, 013207-21, 013353-21, 013354-21, 013358-21, 013454-21, 013857-21, 014529-21, 014808-21, 015127-21, 015166-21, 015447-21, 015659-21, 016762-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 14, 2022(A1)
Licensee / Titulaire de permis :	Albright Gardens Homes, Incorporated 5050 Hillside Drive, Beamsville, ON, L0R-1B2
LTC Home / Foyer de SLD :	Albright Gardens Homes, Incorporated 5050 Hillside Drive, Beamsville, ON, L0R-1B2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	William ter Harmsel

To Albright Gardens Homes, Incorporated, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall be compliant with Ontario Regulation 79/10 section 31(3).

Specifically, the licensee shall prepare, submit and implement a plan to ensure that their staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs.

The plan must include, but is not limited to, how the licensee will initiate/complete the items listed below, by whom and when related to:
a. recruit and retain staff to work in the nursing department to meet the assessed care and safety needs of the residents;
b. review and as necessary revise the staffing mix and levels each time there is a change in resident occupancy levels or care needs to ensure that the staffing pattern is suitable to meet the assessed care and safety needs of the residents and make all reasonable efforts to staff the department to the

identified mix;
c. ensure that the staffing mix and levels are sufficient to ensure that the following assessed care and safety needs are achieved for each resident including, but not limited to:
i. safe transferring and positioning;
ii. bathing at a minimum of twice a week and by the resident's method of choice;
iii. care is provided as set out in the plan of care;
iv. ensuring that residents are dressed suitable for the time of day;
v. repositioning dependent residents as required;
vi. providing nourishments including a between meal beverage three times a day;
vii. ensuring that no residents are served an evening meal until at least 1700 hours and all meals are served course by course; and
viii. ensuring call bells are answered in a timely fashion.
d. maintain a record of all recruitment and retention efforts, each review and all revisions of the staffing mix and levels including the rational; and
e. share with the Residents' and Family Councils and with front line staff in meetings the current staffing pattern and mix in the home for the nursing department and answer any questions related to the staffing pattern and mix and maintain a record of the meetings.

Additionally, the home shall work closely with the Home and Community Care Support Services to develop and implement a resident admission plan.

Please submit the written plan for achieving compliance for inspection # 2021_916168_0011 to Lisa Vink #168, LTC Homes Inspector, MLTC, by email to HamiltonSAO.MOH@ontario.ca by December 24, 2021.

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

Grounds / Motifs :

1. The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

The Ministry of Long-Term Care (MOLTC) received a number of complaints regarding shortages of staff in the home. These complaints were received from staff,

family members and residents. The complaints identified resident specific care needs which staff were not able to meet, or not within the required time frame due to the staffing complement.

The home had a licensed capacity of 231 beds.
The Daily Staffing Report provided a breakdown of staff for the nursing department by role, shift and resident home area.
When the home had a full resident occupancy their planned staffing mix, as identified in the Daily Staffing Report, which did not include management was: 2 RNs, 8 RPNs, and 30 PSW staff on the day shift; 2 RNs, 8 RPNs and 24 PSW staff on the evening shift; and total of 4 registered staff ensuring at least 1 RN and 9 PSW staff on the night shift.

The home had a reduced occupancy, with approximately 50 vacant beds, in the spring of 2021, when a decision was made that the nursing department was able to be staffed with a reduced complement of PSW hours.
Written direction identified that PSW shifts were to be filled without going into overtime, unless the home was greater than 6 unfilled PSW shifts on the day shift or 4 unfilled PSW shifts on the evening shift.
Unfilled RPN shifts were to be replaced with another RPN unless this required overtime at which time the RN would take over the RPN assigned duties on the day and evening shifts, in addition to their regular assignment.
On the night shift if there was an unfilled RPN shift, 1 of the RNs was to take over the assigned RPN duties and if there were 2 unfilled RPN shifts then the RN was to complete RPN duties and overtime could be utilized or agency staff.

Records provided by the home identified that their occupancy level increased in the summer of 2021 with 190 residents in June 2021, 199 residents in July 2021 and 203 residents in August 2021.
At the time of the inspection the targeted occupancy was 200 residents and this was achieved and maintained with admissions.
The reduced staffing direction provided in the spring of 2021 had not changed when the resident occupancy increased, as confirmed by the staff.
The home continued to replace shifts at the reduced staff complement despite an increase in the number of residents in the home.
The home did provide cross training to non-nursing staff to allow them to assist in situations of nursing staff shortages in areas such as feeding, spotting for lifts and

transfers and other tasks.
The home increased their complement of staff in a department and included the distribution of nourishments into their job routines on specific shifts, a task previously completed by PSW staff.
The home provided written direction to utilize in situations of working below the desired staffing complement as an overview of the care needs of each resident home area to assist in reassigning staff, as needed.

A request was made to review 28 specific dates, a sampling of the Daily Staffing Reports, over a time frame of 15 weeks for staffing levels and mix.
i. The sampling identified that the home worked both below their planned PSW staffing as set out in the Daily Staffing Report and their reduced staffing complement, on a number of day, evening and night shifts, during the identified time period.
There were 11 occasions where there were 23 or less PSW staff on the day shift; an occasion where there was only 10 PSWs on the evening shift; and six occasions where there were 7 or less PSWs on the night shift.
ii. The sampling identified that the number of RPNs working, was below the desired staffing complement on 35 occasions, including on one occasion when there was only 5 RPNs in the home on the day shift until 1030 hours, and on a second occasion when there were 6 RPNs on the evening shift.
iii. The sampling identified eight occasions where there was only 1 RN in the home on the day or evening shift. Additionally, it was identified that on two occasions there were only 3 registered staff in the home on the night shift.

Management staff reported that a "Critical Issues Meeting" was held in August 2021, to review staffing/occupancy. At this time there were no changes made to the staffing complement and they continued to work, without offering overtime unless they were up to 6 unfilled PSW shifts on the day shift and up to 4 unfilled PSW shifts on the evening shift.

Resident Council Meeting Minutes for August 2021, included that some floors did not receive bedtime nourishment consistently; and identified the current occupancy was 207 residents.
Resident Council Meeting Minutes, for September 2021, included the occupancy was 202 residents and that new admissions were on hold until January 2022, to ensure staffing levels were sufficient for resident occupancy, a nursing staffing plan was developed to recruit/retain additional staff and a plan was developed to address

resident care.
Resident Council Meeting Minutes, for October 2021, included that a resident home area had only one regular staff and two students who worked one evening and residents felt like they were imposing if they rang their call bell.

Family Council Meeting Minutes, in October 2021, included a discussion related to staffing concerns.

During this inspection areas of non-compliance were identified which supported that the staffing mix was not consistent with residents' assessed care and safety needs, including:

A. Unsafe transferring or positioning of residents:
i. The plan of care identified that the resident required assistance with two staff and a device for transfers.
Interviews with two staff confirmed awareness of recent occasions where staff transferred the resident with one staff and the device without incident, despite the directions in the plan of care due to insufficient staffing.

ii. A staff was observed to use a device to transfer a resident from one position to another. The staff was also observed to leave the resident with the device in place when they left the room and walked down the hall, for a few moments.
A review of the resident's plan of care identified that they required assistance with two staff and a device for transfers as confirmed by staff.
The staff identified they were unaware the resident required two people for the transfer as they were reassigned from another resident home area, in the middle of the shift as they were short staffed.

B. Failure to complete scheduled bathing or to complete bathing by the resident's method of choice:
i. A resident was identified in their plan of care to require assistance with bathing. According to the resident they were not bathed on two occasions.
A review of the Point Of Care (POC) Follow Up Questions Report for bathing for two months, supported that the resident missed baths and that they received a bed bath on two dates, which was not their preference.
According to statements and documentation, bathing was not provided twice a week or by their preferred method.

ii. A complaint received by the MOLTC specifically identified a resident was not bathed as required.
The resident was identified on the bath list for bathing twice a week and the plan of care noted staff assistance.
A review of the POC Follow Up Questions Report for bathing for a month, noted that the resident was bathed five times out of nine scheduled baths.
Staff identified that it was presumed that the resident was not bathed twice a week, due to a lack of documentation.

iii. The Resident/Family Questionnaire completed on admission identified that a resident's previous routine was a tub bath.
A review of the POC Follow Up Questions Report for bathing for 25 consecutive days included that they received five showers and three bed baths during the identified time period.
According to documentation, bathing was not provided in accordance with their preferences.

iv. A resident voiced a concern related to bathing.
Discussion with the resident noted that at the time of the complaint they had already missed one bath that month and had previously missed baths in the past.
A review of the POC Follow Up Questions Report for bathing for two months, noted that the resident had not been provided nor refused bathing in accordance with the bathing schedule on two dates in the time frame.

v. A resident was identified on the bath list for bathing twice a week.
A review of the POC Follow Up Questions Report for bathing for 24 consecutive days noted that the resident was not bathed on two occasions as scheduled.
It was identified that it was presumed that the resident was not bathed twice a week, due to a lack of documentation.

vi. The Resident/Family Questionnaire completed on admission identified that a resident preferred tub baths.
The resident was not able to answer questions at the time of the inspection related to bathing.
A review of the POC Follow Up Questions Report for bathing for 25 consecutive days included that they received one bath, two showers and five bed baths during the

identified time period.
According to staff statements and documentation, bathing was not provided in accordance with their preference.

Discussion with a staff member who was routinely assigned to complete baths identified that bed baths were frequently completed when the home was short staffed; however, efforts were made to ensure that residents did not receive two bed baths in a row unless that was their preference as noted in the plan.

C. Failure to provide care as set out in the plan of care:
The plan of care for a resident identified that they had a routine after breakfast daily.
i. A progress note included that the family was upset as they found the resident in a location, not consistent with their routine and felt it was due to staff shortage.
Interview with staff confirmed that the plan of care was not followed; that the resident's home area was short staffed and the staff did not follow the resident's routine after breakfast on the identified date.
On a second date the resident was found in a location, not consistent with their routine after breakfast.
Interview with staff confirmed that the plan of care was not followed as the resident's routine was not followed after breakfast.

ii. The plan of care for a resident identified that they would be toileted at a specific time as a fall prevention strategy.
Staff wrote a progress note which included that staff did not toilet the resident related to short staffing on the shift.
The staff confirmed that the plan of care was not followed as the home was short staffed on the identified shift.

iii. A review of the plan of care for a resident included to turn and reposition every two hours while awake and every four hours (when in bed) to prevent skin breakdown and promote sleep.
The resident was observed in bed, dressed in street clothing at 1825 hours and additional observations during the shift noted no changes in their position.
After 2200 hours, staff confirmed that for a period of time greater than three and a half hours the resident did not receive care and that the staff had worked short on the identified shift.
Care was not provided as set out in the plan of care related to positioning.

D. Failure to ensure that residents were dressed suitable for the time of day:
Three residents were observed on a resident home area to be dressed in their sleepwear at 1530 hours.
The plans of care for each resident noted that they would be appropriately dressed and did not identify that they preferred to be dressed in sleepwear prior to the evening meal.
Staff identified that the practice of dressing specified residents in their bedtime clothing early in the afternoon was initiated to assist when there were staffing concerns to ensure that care was being completed.

E. Failure to reposition a resident as required:
A resident was observed being put to bed at 1745 hours.
No additional care or repositioning was provided to the resident between 1745 hours and 2215 hours, as confirmed by staff.
Staff also reported that they worked short on the identified shift.
The resident had a plan of care that identified they were dependent on staff for repositioning and were at risk for skin breakdown.
Staff confirmed that the resident should have been repositioned every two hours and the risk of not being repositioned every two hours was the potential for skin breakdown.

F. Failure to offer or provide beverages at the frequency of three between meal beverages:
i. A complaint was received that the morning beverages were not offered or served in a specific resident home area over the course of four specific dates, due to staffing issues.
A review of POC records for the amount of fluids taken at nourishment for three residents identified that they had not been completed for the morning beverage nourishment.
Interview with staff confirmed that morning beverages were not offered or served on the identified dates in the home area.

ii. A staff confirmed that they had not completed the morning beverage nourishment on a specific date due to staffing issues on a resident home area.
A review of POC records for the amount of fluids taken at nourishment for three residents identified that the records had not been completed for the morning

beverage nourishment.

iii. A review of POC records for the amount of fluids taken at nourishment for three resident had been left blank for the morning beverage nourishment on a specific date in a resident home area.
Staff confirmed that only residents with labelled nourishments received morning beverages on that day due to the staffing shortages.

G. Failure to serve the evening meal until at least 1700 hours:
i. A staff member reported that residents on a modified diet were served their meal prior to 1700 hours.

ii. At 1630 hours approximately 12 residents were seated and served their modified diet meal in a dining room of a resident home area.
Staff identified the routine to serve residents on a modified diet prior to 1700 hours, was initiated during the COVID-19 pandemic and continued due to staffing shortages, as this allowed staff to assist the residents prior to meal service for all residents.

iii. At 1640 hours five residents were served their modified diet meal in a dining room and at 1651 hours three additional residents were served their modified diet meal.
Staff identified that the routine to serve residents on a modified diet prior to 1700 hours was in place due to staffing shortages and allowed staff to assist the residents prior to the meal service for all other residents.

H. Failure to serve meals course by course:
Observation of a meal in a dining room identified that residents had not completed their entrée when the dessert had already been served.
Staff confirmed that the residents were not served course by course and verified the routine of serving dessert while the entrée was still being consumed was not in the resident's plans of care nor indicated by their assessed needs.
Staff reported that they worked short on the shift that the meal was observed.

Additionally, concerns were raised related to staff response time to the communication and response system.
A review of call bell logs for a resident noted that:
i. On a day shift there was an occasion where it took approximately 10 minutes for

staff to cancel the alarm.
ii. On another day shift there were two occasions where it took approximately 10 minutes for staff to cancel the alarm.
iii. On an evening shift there were two occasions where it took staff over 25 minutes to cancel the alarm, one occasion where it took over 15 minutes to cancel the alarm and one occasion where it took approximately 10 minutes to cancel the alarm. A progress note identified concerns from the resident's family, on this shift, regarding the length of time it took for staff to respond to the call bell.
iv. On a second evening shift there was an occasion where it took staff over 25 minutes to cancel the alarm.

The home reported that they currently had 3 full time and 30 part time PSW positions to be filled; 2 full time and 5 part time RPN positions to be filled; and 4 part time RN positions to be filled. It was identified that the home had staff who would not be able to work in the home due to COVID-19 vaccination status.

In an effort to fill vacant nursing department shifts the home had established relationships with five staffing agencies.

It was identified that the home had or were in the process of implementing some strategies which would assist in the retention of some current nursing staff.

Following a discussion during the inspection it was identified that the exact date that the written direction related to reduced PSW staffing levels and offering of overtime was unknown as was the author of the written direction which was provided in the spring of 2021.
During the inspection a decision was made that effective immediately the home would attempt to replace all unfilled shifts as needed to achieve the staffing plan as set out in the Daily Staffing Report, with the exception of 3 PSW shifts on the day shift.

The staffing plan did not provide for a staff mix that was consistent with residents' assessed care and safety needs which resulted in risk of harm to residents in the home; when they failed to reevaluate staffing levels when there was an increase in the number of residents in the home. This resulted in unmet or a delay in meeting resident care needs.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Sources: Observations of the provision of care and services, a review of clinical health records; Daily Staffing Reports; meeting minutes; call bell logs and bathing schedules and interviews with residents and family members and staff.

An order was made by taking the following factors into account:
Severity: There was the potential for risk or harm to the residents as a result.
Scope: This was a widespread issue impacting the entire home.
Compliance History: In the last 36 months, eight other Compliance Orders were issued to different sections of the legislation, which have all been complied. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 24, 2022(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 14th day of January, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by LISA VINK (168) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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