Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 6, Dec 8, 2017	2017_623626_0016	019232-17	Resident Quality Inspection

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Case Manor Care Community
28 BOYD STREET P.O. BOX 670 BOBCAYGEON ON K0M 1A0

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

DENISE BROWN (626), CRISTINA MONTOYA (461), JENNIFER BATTEN (672), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 18, 19, 20, 21, 22, 25, 26, 27, 28, 29 and October 2, 2017

The following were inspected during the course of the Resident Quality Inspection:

1. Critical Incident Logs:

Log #012232-17: Related to fall
Log #021534-17: Related to fall

2. Complaint Log:

Log #022061-17: Related to resident care

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Director of Environmental Services (DES), acting Assistant Director of Care (ADOC), Director of Dietary Services (DDS), Registered Dietitian, Physiotherapist, Restorative Care Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Worker (FSW), Dietary Aide, Laundry Aide, Family and Resident's Council presidents, residents and family members.

During the inspection the Inspector (s), toured the residents' home areas, observed staff to resident provision of care, resident to resident interactions, infection control practices and medication administration. The Inspectors reviewed residents' health records, internal related investigations, maintenance records, applicable policies, resident and family council minutes, complaints and critical incidents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **15 WN(s)**
- **6 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 71. (3)	CO #901	2017_623626_0016	626

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	Legendé 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. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents are offered a minimum of three meals daily, specifically the breakfast meal.

On a specified date during an interview, resident #020 indicated to Inspector #672, that there were some mornings that the resident did not receive breakfast. The resident also indicated that on specified occasions being served a drink and snack when breakfast was not provided.

The home has a number of resident home areas each with separate dining rooms. Inspector #672 observed the breakfast meal service in all dining rooms on four separate dates and noted the following;

Inspector #672 observed the breakfast meal service on a specified date in all dining rooms within the home, and made the following observations:

On the same specified date on an identified resident home area, Inspector #672 observed that residents #014, #016, #020 and #041 were not in the dining room for breakfast. During an interview Personal Support Worker (PSW) #107 indicated that only one of the identified residents preferred to sleep in late in the mornings.

PSW #107 indicated, that resident #020 did not attend the dining room on an identified date and a tray was provided to the resident.

PSW #108 indicated that resident #014 was sleeping and had refused breakfast, which was verified by the Inspector. PSW #108 also indicated that the resident would receive a drink and snack later that morning.

In another identified resident home area and on the same date, Inspector #672 observed that residents #049 and #031 were not in the dining room for breakfast.

On a different identified resident area on the same specified date Inspector #672

observed that residents #001, #006, #047 and #046, did not attend the dining room for breakfast. PSW #119 indicated, that the residents would receive fluids and a snack but when it was offered resident #001 refused.

In an interview with Inspector #672, the Food Service Worker (FSW) #120 indicated, that it is acceptable for residents to go into the dining room for breakfast in their house coats and/or pyjamas. The FSW further added that if the residents were not comfortable with attending breakfast in the dining room wearing their house coats and/or pyjamas, they would be provided with cereal as an alternative at a specified time.

Inspector #672 interviewed the Director of Care (DOC), regarding the breakfast meal observations which were made. The DOC indicated being aware of the fact that some residents were missing the breakfast meal and this was a previous complaint from some residents and family members. DOC further indicated, that it was acceptable for residents to attend the dining room in their housecoats and/or pyjamas, if the residents were comfortable with that decision, and it was never acceptable for a resident to miss attending a meal due to a staffing concern. The DOC indicated that even if staff were running out of time, that it should always be the resident's choice and at a minimum, the residents should receive a continental breakfast meal, if they were not able to arrive to the dining room before the breakfast meal was completed.

Inspector #672 observed the breakfast meal on a second specified date, in all dining rooms within the home and made the following observations:

Observations by Inspector #672 of the breakfast meal on an identified resident home area, indicated that residents #014, #026 and #051, did not attend the dining room for breakfast. During an interview, PSW #129 indicated that residents #014, #026 and #051 were left in bed, as it was in each resident's written plan of care to remain in bed until after the breakfast meal. PSW #129 further indicated, that the residents would not receive tray service or be brought to the dining room following the dining service for a continental breakfast, but the residents would receive fluids and a snack after the breakfast service.

Observations by Inspector #672 of the breakfast meal on another identified resident home area, indicated that residents #049 and #031 did not attend the dining room for breakfast. During an interview, PSW #129 indicated, that the residents did not attend the breakfast meal that morning due to staff running out of time, and could not provide personal care prior to breakfast. PSW #129 further indicated, that the residents would not

receive tray service but would receive fluids and a snack after the breakfast service.

Observations by Inspector #672 of the breakfast meal on a different resident home area indicated, that residents #009, #006, #010, #052, #012, #053 and #054, did not attend the dining room for the breakfast meal. During an interview, PSW #119 indicated that only one of the identified residents, who did not attend the dining room would not receive tray service but would receive fluids and a snack after the breakfast service.

Inspector #672 observed the breakfast meal on a third specified date, in all dining rooms within the home and made the following observations:

Observations by Inspector #672 of the breakfast meal on an identified resident home area indicated, that residents #015, #028, #055, #051, #019 and #056, did not attend the dining room for the breakfast meal. During an interview, PSW #107 indicated that residents #015, #028, #055, #051 and #019 were all sleeping, therefore staff did not awaken them to attend the dining room for breakfast, and resident #056 only attended the dining room for breakfast when the resident desired. PSW #107 further indicated, that the residents would not receive trays but would receive fluids and a snack after the breakfast service.

Observations by Inspector #672 of the breakfast meal on another identified resident home area, revealed residents #057, #049, #039, #048 and #031 did not attend the dining room. During an interview, PSW #131 indicated that resident #057 did not attend the dining room for the breakfast meal, as the resident had been noted to be sleeping soundly and staff did not want to awaken the resident. The PSW also indicated, that resident #049 had not been feeling well. During an interview, PSW #132 indicated, that resident #039 did not attend the dining room as the transfer device in the resident's room was not working, therefore the resident could not be transferred out of bed. The PSW also indicated, that resident #031 did not attend the dining room as the PSW had run out of time to provide the resident with assistance.

Observations by Inspector #672 of the breakfast meal on a different resident home area, revealed that residents #001, #004, #005, #006, #010, #011, #046, #047, #052, #058, #059 and #060, did not attend the dining room for the breakfast meal. During an interview PSW #119 indicated, that residents #006, #010 and #011, did not attend the dining room, as the PSW had run out of time to provide the residents with assistance prior to the breakfast meal. PSW #119 further indicated, that the residents would not receive tray service but would receive fluids and a snack after the breakfast service.

Inspector #672 observed the breakfast meal on a fourth specified date and made the following observations:

Observations by Inspector #672 of the breakfast meal on an identified resident home area, revealed that residents #051, #055, #019, #014 and #041 did not attend the dining room for breakfast. During an interview, PSW #107 indicated that all of the residents who did not attend the dining room had been noted to be sleeping soundly that morning, therefore staff did not want to awaken them. The PSW further indicated, that the residents who did not attend the dining room for breakfast would not receive a continental breakfast meal but would receive fluids and a snack after the breakfast service.

Observations by Inspector #672 of the breakfast meal on an identified resident home area, revealed that resident #039 did not attend the dining room, as the resident was sleeping. During an interview, PSW #132 indicated that the resident would not receive a continental breakfast upon awakening, but would receive fluids and a snack after the breakfast service.

Observations by Inspector #672 of the breakfast meal on a different resident home area, revealed that residents #001, #002, #006, #007, #011, #047 and #053, did not attend the dining room for breakfast. During an interview, PSW #138 indicated that all residents who did not attend the dining room had been noted to be sleeping, except residents #001 and #002, who refused to attend the dining room that morning. PSW #138 further indicated, that the residents who did not attend the dining room for breakfast that morning would not be served a continental breakfast, but would receive fluids and a snack after the breakfast service.

On the first specified date, Inspector #672 interviewed the Registered Dietician (RD), who indicated that the dietary services is expected to offer the residents a "Late Riser Continental Breakfast", which was available to all residents up to 1000 hours daily. If residents were not arriving to the dining room on time to have the regular breakfast meal, the continental meal should be offered to the resident, which consisted of cold cereal, toast, a hot drink and a cold drink, which would be prepared by the PSW nursing staff. The RD further indicated, that it should always be the resident's choice, whether or not they attend the dining room for the breakfast meal service. This decision should not be impacted by staffing issues, such as running out of time or related to the bathing schedule. It was also an acceptable option for the residents to attend the dining room in

their housecoat and/or pyjamas, if the resident desired and was comfortable.

On the fourth specified date, Inspector #461 interviewed the Director of Dietary Services (DDS), who indicated not having been aware that there were residents in the home who were not consistently receiving a breakfast meal, either in the dining room, or the resident's room. The DDS further indicated, that the expectation was that residents who were noted to be early risers (awakening at a specified time) were to be offered a continental breakfast which contained cold cereal, milk, toast, tea and coffee, if they were hungry and requesting a meal before the breakfast service. For the residents who chose to sleep in, the expectation was that the residents were to be offered a continental breakfast up to 1000 hours. After that 1000 hours, the residents were to receive a beverage, along with an assortment of cookies or the staff could access muffins from the servery, if the residents preferred.

The licensee has failed to ensure that all residents are offered a minimum of three meals daily, specifically the breakfast meal. [s. 71. (3) (a)]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one Registered Nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times, except as provided for in the Regulations.

O. Reg 79/10 s.45(2)(i)(ii)(A)(B) for 24 hour nursing care – exemptions;

For a home with a licensed bed capacity of more than 64 beds and fewer than 129 beds,

-in the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used,

-in the case of an emergency where the back-up plan referred to in clause 31(3) (d) of this regulation fails to ensure that the requirement under subsection 8(3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third part may be used if,

-The Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and

-a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

According to O.Reg. 79/10, s.45(1) the definition of an "emergency" is as follows: "Emergency means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the long-term care home."

The home has a licensed bed capacity of ninety-six beds.

During an interview on a specified date, the DOC indicated that the licensee was struggling with recruitment and retention of Registered Nursing staff. Due to frequent struggles to fill Registered Nurse (RN) shifts, the licensee maintained contracts with two separate nursing staff support agencies. The DOC further indicated, that there had been vacant RN shifts on the schedule over the previous three months, when the licensee had been unable to fill the shifts with RN staff members of the home and the agencies were unable to provide a Registered Nurse. This lead to the home operating without an RN on duty.

On a specified date, Inspector #672 was provided with a copy of the home staffing plan, along with the RN staff schedules for a specified time period. Review of the RN staff

schedules for the specified time period, identified that there were a number of shifts where the home did not have an RN present and on duty.

During an interview on a specified date, the DOC indicated that on the dates when an RN was not present and on duty in the home, no emergencies had occurred to prevent the RN from attending the vacant shift.

The licensee failed to ensure that at least one Registered Nurse, who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times, during the identified period, when there were a number of shifts where the home did not have an RN present and on duty. [s. 8. (3)]

Additional Required Actions:

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

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident

that sets out clear directions to staff who provide direct care to the resident, related to bathing.

Related to Log #022061-17 for resident #007

A review of the resident’s medical records specifically the home's electronic documentation system for a specified time period, indicated that the resident received two baths during this period. The electronic documentation system's information indicated, that the resident was provided a bath on two identified dates in a specified month and refused a bath on another specified date. There was also documentation to indicate “not applicable” on four other specified dates within the same month.

A review of resident #007’s current written care plan on a specified date, outlined specific interventions for bathing. These interventions identified the bath days and required documentation. A review of the bath schedule on a specified date indicated, that the resident`s bath days on this schedule were different from the written care plan.

In an interview, the resident denied refusing baths and indicated not having many baths, as the staff may have been busy. During an interview with PSW #127 on a specified date, the PSW indicated that when the bath days changed, it was not updated in the home's electronic documentation system and not applicable was documented on the scheduled days that were incorrect. When the bath was provided on another day, it was documented under the as needed (PRN) section of the home's documentation software. The PSW also indicate that the charge nurse was informed and the bath days were corrected.

In another interview, RN #126 indicated that the resident’s bath days were to take place on two specified days. The scheduled bath days for the resident were noted in the written care plan to be on two different specified days from the days indicated by the RN. The RN also indicated that at the time of the interview, the current bath schedule and designated days on the written plan of care were corrected and were accurate.

The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff who provide direct care. Resident #007’s scheduled bath days were not adjusted in the written plan of care and the home's documentation software to reflect the change. [s. 6. (1) (c)] (626)

2. The licensee has failed to ensure that when the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care related to falls prevention.

Related to resident #037

During the inspection, resident #037 was identified to have sustained a fall in the last 30 days. Review of the progress notes for resident #037 by Inspector #570, indicated the resident sustained a number of falls in a three month period.

Progress notes reviewed by Inspector #570 indicated, that on a specified date (after sustaining two falls on one specified date), resident #037 was assessed by the Physiotherapist (PT) for a mobility device. The Physiotherapist's note indicated, that the resident used a basic mobility device that did not meet the resident's needs.

Review of the current written plan of care for resident #037 by Inspector #570 indicated, that the resident was at high risk for falls related to history of falls/injury and multiple risk factor. The current plan of care outlined interventions for falls prevention. The plan of care review indicated, that the most recent revision of the plan occurred on a specific date and included one intervention for falls prevention. The plan did not indicate, that revisions were made pertaining to any new approaches or interventions after this specific date in which the resident sustained a number of falls.

On a specified date, Registered Practical Nurse (RPN) #106 indicated no awareness of any new approaches used for falls prevention other than interventions included in the plan of care.

During an interview, the DOC indicated, that the plan of care for resident #037, should have been reviewed and revised when the interventions in place were not effective in preventing falls.

On specified date during an interview, the physiotherapist indicated that the resident was assessed for a new mobility device but was not provided with loaner device, when it was determined that the resident's current device was not meeting the resident's needs and no direction was given to staff.

The licensee failed to revise the resident's plan of care when care set out in the plan was

not effective. There was no indication the written plan of care for resident #037 was revised and other interventions considered, when the resident sustained a number of falls during a three months period. s. 6. (11) (b)] (570)

3. The licensee has failed to ensure that when the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care, related to falls risk.

Related to Log #012232-17 for resident #043

A Critical Incident Report (CIR) was submitted to the Director on a specified date, for a fall incident that occurred on the same specified date. The CIR indicated that on this specified date, resident #043 fell and sustained an injury.

Review of the progress notes for resident #043 by Inspector #570 indicated, that the resident sustained a number of falls in a three month period.

Review of the most recent plan of care for resident #043 dated on a specified date by Inspector #570, indicated that the resident was at moderate risk for falls related to history of falls/injury and multiple risk factors. The plan of care listed some intervention related to falls prevention.

The plan of care review related to falls did not indicate any new approaches or interventions put in place to prevent falls, although the resident had a number of falls within a three month period. The plan of care related to falls was revised on a specified date after the most recent fall to include one intervention although, the resident had sustained a number of falls previous to when this revision was made.

During three separate interviews with PSW #107, PSW #108 and RPN #103, the staff interviewed did not indicate any new interventions or revisions to the plan of care.

During an interview, the DOC indicated that plan of care for resident #043 should have been reviewed and revised when the intervention in place were not effective in preventing falls.

The licensee failed to revise the resident's plan of care when care set out in the plan was

not effective. There was no indication that the written plan of care for resident #043 was revised and other interventions considered, when the resident continued to fall when the interventions in place for falls prevention were ineffective. [s. 6. (11) (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, the following provisions in regards to the plan of care: that the plan set out clear directions to staff and others who provide direct care to residents; when the plan of care is being revised because the care set out in the plan has not been effective, that the licensee shall ensure that different approaches are considered in the revision of the plan of care, related to residents #037and #043, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept locked when not supervised by staff.

During the initial tour of the home Inspector #672 observed the following:

The Information Centre on an identified resident home area was noted to have one door left open. The Information Centre is the nursing station of the resident home area which stores confidential personal and medical information for each resident, who resides on

the identified area. At the time of the observation, there were several residents noted to be in the immediate area, sitting in front of the nursing station and in the hallway. There were no staff members noted in the immediate area. This observation was shared with RPN #140, who agreed that the Information Centre was a non-residential area and should not have been left open. The RPN closed the door to the Information Centre following the conversation.

The tub room on an another identified resident home area was noted to be unlocked, as the door was noted to not fully close and latch on its own, unless firmly pulled closed. This room was noted to store personal care items, sharps containers, disinfectants for the bathtub and transfer equipment. There was one resident noted to be in the immediate area of the tub room at the time of the observation and there were no staff members present. This observation was shared with PSW #118, who indicated the tub room was a non-residential area, which should be kept closed and locked when staff were not present and the door was to be pulled firmly to closed.

The "Oxygen room" door on the same identified resident home area is to be kept closed and locked at all times, when not in use and utilizes a swipe card to access the room. The door was noted to not be fully closed and/or locked, as Inspector #672 was able to push the door open, without utilization of a swipe card. The room was observed to store oxygen canisters, personal care items and nursing supplies. At the time of the observation, there were two residents noted to be in the hallway just outside of the room and no staff members were in the area. This observation was immediately shared with PSW #118 and RPN #140. The RPN was able to get the door to properly close and lock following several attempts. RPN #140 indicated, that the Oxygen room is a non-residential area and should be kept closed and locked at all times.

The above observations were shared with the DOC following completion of the tour in the home.

On another specified date at an identified time of day, Inspector #672 was on a resident home area and noted that the door to an identified room which is a non- resident area was not fully closed and locked, as the door was able to be pushed open, without the use of a swipe card. At the time of the observation, there were two residents noted to be in the immediate area and no staff members were present. This observation was shared with PSW #118, as the registered staff was not present on the unit and had gone for break. The PSW indicated that the identified room is a non-residential area, it should be kept closed and locked at all times when unsupervised by staff. The PSW was able to

pull the door closed and also ensured that the lock was engaged. This observation was shared with the DOC.

On a different specified date, at an identified time of day, Inspector #672 was on the same identified resident home area and noted that the same identified room door was not fully closed and locked. The Inspector was able to push the door open without using a swipe card. This observation was shared with RPN #103, who indicated that the identified room is a non-residential area that should be kept closed and locked at all times when not supervised by staff. The door to the identified room, should also be pulled closed and staff must ensure that the lock is engaged. Inspector #672 was again on the same identified resident home area at another identified time of day and observed that the door to the same identified room was not fully closed and locked. Once again the door could be pushed opened without the use of a swipe card. This observation was again shared with RPN #103, who came to ensure the door was closed and locked properly. The RPN was able to successfully lock the door after four attempts and engaging the latch mechanism on the fourth attempt. These observations were shared with the DOC, who indicated that, the Director of Environmental Services (DES) was informed about the door not closing and locking properly. The DOC further indicated, that the DES was planning to change the locks on the doors leading to non-residential areas, that were currently secured by swipe cards to keypad locks. The DOC indicated that changing the door locks to a keypad mechanisms would assist in resolving the issue of the doors not closing and locking properly. The DOC was unsure of when these changes would be fully implemented.

On another specified date, Inspector #672 was on the same resident home area and noted that the same identified room door was not fully closed and locked. The Inspector was able to push the door open without the use of a swipe card. This observation was shared with RN #136, who agreed that the room is a non-residential area that should be kept closed and locked when staff are not present to supervise the area. This RN was able to lock the door by engaging the latch on the door after several attempts.

During an interview on the same specified date, the DES indicated, that he had been informed about the concern related to the doors leading to non-residential areas not being able to close and lock properly. The DES also indicated, that he had adjusted the mechanism on the doors which would cause the doors to close in a faster motion, ensuring that the lock mechanism was fully engaged. The DES further indicated, that the doors were to non- resident areas and should be kept locked at all times, when staff were not present to supervise. The DES indicated, that he would have the swipe card locks

changed over to keypad lock mechanisms within a one month period.

The licensee failed to ensure all doors leading to non-residential areas were kept locked when not supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure, that there is a process in place and monitored in order to safeguard that all door leading to non-residential areas are locked when not supervised by staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff, and visitors at all times.

During the initial tour of the home, Inspector #672 observed that an identified common area in a specific resident home area, where resident #061's was located, the resident did not have access to the call bell. The resident's bed was placed against the southern wall of the room, and the call bell was noted to be on the northern wall, with a space of approximately 14 feet between the bed and the call bell. The call bell system was noted to be a push button call bell with no string attached, therefore to activate the call bell, the button on the wall needed to be pushed directly.

Inspector #672 interviewed RPN #125 on a specified date, indicated that resident #061 did not have access to the call bell system but the resident was observed closely by staff. Inspector #672 requested to review the documentation for the increased observation and RPN #125 indicated, that the resident was not receiving formal increased observation, but staff were keeping a closer eye on the resident.

On a specified date, Inspector #672 observed resident #017 in a mobility device which was located in the middle of the room. Resident #017's call bell was noted to be on the floor on the far left side of the bed, where the resident could not access the call bell. This observation was shared with PSW #101, who secured the call bell to the far right of the bed, where it could then be accessible for resident #017, should assistance be required.

On another specified date, Inspector #672 again observed resident #017 in a mobility device in the bedroom, which was located in the middle of the room. Resident #017's call bell was noted to be on the floor on the far left side of the bed, where the resident could not access the call bell. This observation was shared with PSW #107, who secured the call bell to the far right of the bed, where it could then be accessed by resident #017, should assistance be required.

On a specified date, Inspector #672 was conducting an interview with resident #013, in the resident's bedroom. Resident #013 was in a mobility device which was located on the right side of the bed. The bedroom was noted to be quite warm and resident #013 was feeling thirsty, therefore requested the call bell to call for staff assistance to provide a cool drink. Resident #013's call bell was noted to be tied to the left bedrail, and hanging down between the bedrail and mattress, which could not be accessed by resident #013. Resident #013 informed Inspector #672, that the call bell is rarely within reach, when in

the mobility device. This information was provided to PSW #108, who gave assurance that the message was passed along to the rest of the front line staff, to ensure the call bell was within resident #013's reach.

On another specified date, Inspector #672 was in the meeting room, which was located down the hall from resident #013's bedroom, when resident #013 was heard to be calling out for staff. Inspector #672 heard the resident call out several times, then approached resident #013's bedroom, to ensure that the resident was safe. Resident #013 was calling out in an attempt to get staff's attention, as the call bell was not accessible. The call bell was tied to the left bedrail of the bed, hanging down between the mattress and the bedrail, and resident #013 was noted to be in a mobility device which was located on the right side of the bed. PSW #108 assisted resident #013 and ensured that the call bell was moved to be in the resident's reach.

On a different specified date, Inspector #672 overheard resident #013 calling out for staff assistance. Resident #013 called out three times, prior to staff arriving to inquire about the resident's needs. Inspector #672 entered resident #013's bedroom and observed that the call bell was on the floor and was not within the resident's reach. This was reported to PSW #107, who moved the call bell in order for it to be accessible to the resident.

The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident-staff communication and response system is available in every area; can be easily seen; is available at each bed , toilet, bath and shower location used by residents; is accessible by residents, staff and visitors at all times, related to resident # 013, #017 and #061, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged incident that the licensee knew of, or that was reported was immediately investigated, related to an allegation of staff to resident verbal abuse and neglect.

Resident #020 informed Inspector #672 of being involved in an incident with PSW #110, in which the resident felt that the PSW had spoken to the resident in a rude and demeaning way. The PSW had also refused to provide assistance with transportation for the resident to attend the dining room for a meal. Resident #020 further indicated, that on this specified date a spill occurred in the resident's room. The housekeeping staff was informed by the charge nurse, who stated housekeeping would be in to clean the area in a few minutes. Resident #020, then requested PSW #110's assistance to get to the dining room for the meal service. According to resident #020, PSW #110 stated in a harsh tone that the resident had to wait in the bedroom until the spill was cleaned up. Resident #020 further indicated, that an explanation was provided to the PSW that the resident was feeling hungry that morning and was concerned about missing the meal service. Resident #020 indicated, that PSW #110's response was that the resident will just have to wait and refused to provide assistance with transportation to the dining room. Resident #020 indicated having cleaned up the spill, in the hope that this would persuade PSW #110, to provide assistance to the dining room. The PSW continued to refuse assistance to the resident with transportation, until the housekeeping staff arrived. The resident indicated, that the home's management team was not informed of the incident.

Following the interview with resident #020 on a specified date, Inspector #672 immediately informed the DOC of resident #020's allegations. The DOC indicated, that the alleged incident would be investigated.

On another specified date, Inspector #672 requested from the DOC an update regarding the status of the investigation. The DOC informed Inspector #672 that the investigation was not initiated at that time. On a later specified date, Inspector #672 approached the DOC and requested another update related to the investigation pertaining to resident #020's allegations. The DOC informed Inspector #672, that the investigation was not initiated.

The licensee has failed to ensure that every alleged incident that the licensee knew of, or that was reported was immediately investigated, related to an allegation of staff to resident verbal abuse and neglect. The licensee became aware of the allegation from resident #020 on a specified date and did not initiate the internal investigation until five days after being informed. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a process in place and monitored to guarantee that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated; any requirements that are provided for in the regulations for investigating and responding as required are complied with, related to resident #020, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had their personal items labelled within 48 hours of admission, and of acquiring, in the case of new items.

On a number of specified dates, during the initial tour of the home, Inspector #672 made the following observations:

On a number of identified resident home areas and in areas commonly used by residents, Inspector #672 observed multiple unlabelled personal items.

During separate interviews on the same specified date, RPN #111 and PSW #117 indicated, that they were unsure of which resident owned the personal items and that the expectation in the home was that all resident personal items, were to be clearly labelled with the resident's name on each item.

During an interview on the same specified date, RPN #140 indicated the expectation was that all resident personal items were to be clearly labelled with each resident's name on them.

In multiple identified resident care area, Inspector #672 observed a number of unlabelled personal items.

During an interview, RPN #142 indicated being unsure of which resident own the items and the expectation in the home was that all personal items were to be labelled with the resident's name on each item.

During an interview, PSW #101 indicated the expectation in the home was that all personal items were to be labelled with the resident's name. The PSW also indicated

being unsure of which residents the personal item belonged.

During another interview, the DOC indicated that the expectation was that all resident personal items were to be immediately labelled when brought into the home. The DOC further indicated, that all nursing staff members had received education regarding the importance of ensuring that each resident's personal items were labelled. The DOC also indicated that residents and family members received education regarding this process during admission to the home, with reminders as needed.

The licensee failed to ensure that each resident of the home had their personal items labelled within 48 hours of admission, and of acquiring, in the case of new items. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a process in place and monitored, in order to safeguard that each resident's personal items are labelled within forty-eight hours of admission and in the case of acquiring new items, to be implemented voluntarily.

WN #8: 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. The licensee failed to ensure all staff participate in the implementation of the infection prevention and control program, related to completion of hand hygiene during completion of the nourishment passes.

On a specified date, Inspector #672 observed PSW #100 and PSW #101 completing part

of the nourishment pass on an identified resident home area. During the nourishment pass, the Inspector observed PSW #100 stop to assist resident #016 with care. Inspector #672 was standing at the doorway to resident #016's room and did not observe PSW #100 stop to complete hand hygiene, prior to returning to the nourishment cart. Upon returning to the nourishment cart, PSW #100 resumed serving fluids and snack items to residents.

During an interview, PSW #100 indicated to Inspector #672, that the expectation was that hand hygiene was to be completed at the beginning and end of each nourishment pass; following completion of personal assistance to residents of any kind; or whenever the hands were soiled, from activities such as sneezing or coughing into the hands, using the washroom, or touching a soiled item, or a resident. Inspector #672 did not observe a bottle of hand sanitizer present on the nourishment cart, but PSW #100 indicated that there were hand hygiene stations available inside every resident room, and in the hallways, between each resident bedroom.

On another specified date, Inspector #672 observed PSW #104 completing part of the nourishment cart on an identified resident home area. During completion of the nourishment cart, the Inspector observed PSW #104 stop to assist resident #048 with care. Inspector #672 also observed a bottle of hand sanitizer present on the top shelf of the nourishment cart. Upon returning to the nourishment cart, PSW #104 resumed serving fluids and snack items to residents, without completion of hand hygiene.

During an interview, PSW #104 indicated the expectation was to complete hand hygiene after providing nourishment to every resident, and before and after providing personal assistance to residents. PSW #104 further indicated, having forgotten to complete hand hygiene after assisting resident #048 and also stating to be behind schedule.

On a different specified date, Inspector #672 observed PSW #119 completing part of the nourishment pass on an identified resident home area. While PSW #119 was completing the nourishment pass, the Inspector did not observe PSW #119 complete hand hygiene between assisting residents, or serving nourishment items to residents. PSW #119 was also observed to carry used drinking glasses out of three resident bedrooms, without completing hand hygiene following each instance of handling a used drinking glass, prior to returning to serve nourishment items to other residents.

During an interview, PSW #119 indicated, that the expectation was to complete hand hygiene at the beginning and completion of the nourishment pass, and admitted not

completing hand hygiene at the beginning of the nourishment pass. A bottle of hand sanitizer was noted to be present on the nourishment cart.

On another specified date, Inspector #672 observed PSW #107 and PSW # 110 completing part of the nourishment pass on an identified resident area. During completion of the nourishment pass, PSW #107 stopped to assist one resident to sit in a chair in the hallway, and stopped to assist in repositioning another resident in a mobility device. Then the PSW returned to the nourishment cart to continue to serve fluids and snack items to residents, without completing hand hygiene.

During an interview, PSW #107 indicated the expectation was to complete hand hygiene at the beginning and completion of the nourishment pass, and after assisting each resident with their nourishment. PSW #107 further indicated having forgotten to complete hand hygiene after assisting each resident.

On the same specified date, Inspector #672 observed PSW #133 completing part of the nourishment pass on another identified resident home area. During completion of the nourishment pass, PSW #133 stopped to assist a resident with putting slippers back on the resident's feet and was noted to remove drinking glasses from two resident rooms. Inspector #672 did not observe the completion of hand hygiene following any of the tasks observed, nor during the nourishment pass.

During an interview, PSW #133 indicated, that the expectation was to only complete hand hygiene at the beginning and end of the nourishment pass.

On a different specified date, Inspector #672 observed PSW #137 completing part of the nourishment pass on a identified resident care area. During completion of the nourishment pass, PSW #137 was observed to remove a drinking glass from a resident room, and stop to assist resident #002 with repositioning in a mobility device. Inspector #672 did not observe PSW #137 complete hand hygiene following either of the observed tasks, prior to returning to the nourishment cart to serve food and fluids to the residents.

During an interview, PSW #137 indicated, that the expectation was to complete hand hygiene between assisting each resident with their nourishment and acknowledged having forgotten to perform the task.

The licensee has failed to ensure that all staff members participate in the infection control program, specifically related to the completion of hand hygiene during nourishment

passes. [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 there is a process in place and monitored, in order to safeguard that all staff participate in the infection control program, to be implemented voluntarily.

WN #9: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff members fully respected and promoted resident #018's right to be afforded privacy, during completion of personal care.

On a specified date, Inspector #672 approached resident #018's bedroom door and knocked, as the door was closed. The Inspector was given permission by the PSW in the room to enter the bedroom. When Inspector #672 entered the bedroom, it was noted that PSW #100 and PSW #101 were providing personal care to resident #018. The PSWs had not pulled the curtain during care to provide privacy to the resident. Resident #018's roommate, resident #017 was present in the room. After Inspector #672 entered the bedroom, PSW #100 closed the privacy curtain.

During an interview, PSW #100 indicated to Inspector #672 that the expectation was that the privacy curtains should be fully closed when other people are present in a room. The bedroom door should also be firmly closed and people should not be invited to enter the room, when personal care is being provided to residents. PSW #100 further indicated, having forgotten to close the privacy curtain for resident #018, as they were rushing to complete the care.

Inspector #672 interviewed PSW #101, who indicated that the expectation was that privacy curtains should be fully closed at all times when providing resident care. PSW #101 further indicated, that the privacy curtain for resident #018 had not been pulled due to rushing to complete the task at hand. PSW #101 also indicated, that the privacy curtains must be closed when providing personal care for each resident.

During an interview, the DOC indicated that it was expected that all staff members provide each resident with privacy at all times, during any treatment or completion of any personal care task, regardless of the resident's medical diagnosis or cognition level.

The licensee failed to ensure that PSW #100 and PSW #101 fully respected and promoted resident #018's right to be afforded privacy, while caring for the resident's personal needs. [s. 3. (1) 8.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with O. Reg. 79/10, s 8 (1) (b)

Under O. Reg. 79/10 s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10 , s. 69.

Inspector #461 reviewed the home's policy "Monitoring of Resident Weights" (#VII-G-20.80, revised on April 2016), which indicated the following:
All unplanned weight loss or gain of 5% in 30 days, 7.5% in 90 days, or 10% in 180 days, and any other weight change that compromises resident's health status, will be assessed and evaluated, and documented by a member of the interdisciplinary care team. A Registered Dietitian referral may be required.

The procedures directed the RN/RPN to:
- Ensure that monthly weights or re-weights are documented in the weights and vitals section of the electronic record by the 10th of every month.
- Investigate potential causes of weight variance, including a review of resident's current eating patterns, hospitalizations within the past month, and related symptoms and observations, i.e. weight gain related to fluid retention.

- Ensure that the PSW reweighs the resident if there is a weight change (loss or gain) of 2 Kg difference in resident's weight from the previous month.
- Complete monthly weight variance reports and respond to weight variances following the electronic documentation process.
- Refer to the dietitian if necessary.

Resident #051 was identified as having a significant weight loss on a specified date. Review of resident's health records showed that resident #051 was at high nutritional risk for a number of stated reasons.

Inspector #461 reviewed resident's health records identifying, that the resident's weight was entered into the electronic documentation system on a specified date. Resident's weight on a previous specified date had showed a significant weight change of 5.8% in a one month period. Resident's weight was entered into the electronic documentation system after a specified date, with no indication that a reweigh was done. Furthermore, there was no assessment completed by the interdisciplinary care team in relation to resident's significant weight change on the identified specified month.

During an interview with the Director of Dietary Services (DDS), the DDS indicated that upon review of the Dietitian's visit book, there was no assessment completed for resident #051 in a specified month, related to significant weight loss. The DDS further reviewed, the resident's records and confirmed that there was no assessment done by the registered staff nor a referral sent to the Registered Dietitian (RD).

During an interview with the Assistant Director of Care (ADOC), the ADOC indicated that the home's expectation is that weights are to be completed by the 10th of each month. The registered staff should assess the potential causes for weight loss and are responsible to initiate a referral to the RD as needed. It is not the RD's responsibility to identify residents with significant weight changes and request the staff to reweigh the residents, as it is the current process in the home. The ADOC acknowledged that the home did not follow the licensee's policy related to assessing the significant weight change for resident #051. The ADOC further indicated, that more staff education is needed to accurately document and assess residents' weight changes as well as to initiate referrals to the RD in a timely manner.

The licensee failed to ensure that its policy for Monitoring of Resident Weights #VII-G-20.80, was complied with, specifically related to the reweighing process, assessing residents' significant weight changes by the interdisciplinary care team, and completing

referrals to the Registered Dietitian if necessary. [s. 8. (1) (a),s. 8. (1) (b)] (461)

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with O. Reg. 79/10, s 8 (1) (b)

Under O. Reg. 79/10 s. 48 (2) (b) each program must, in addition to meeting the requirements set out is section 30, provide for assessment and reassessment instruments.

The licensee's policy #VII-G.30.10, "Pain & Symptom Management" last revised in June, 2017, was reviewed. The policy communicates that residents will be cared for in a manner that supports their quality of living; validating their voice, choice, and goals of care for pain and symptom management.

The policy procedures directs the Registered Staff to:
- When resident reports or exhibits signs and symptoms of pain (greater than 4/10 for 24-48 hours) following implementation of pharmacological and/or non-pharmacological interventions
(i.e. satisfactory pain relief is not achieved following interventions)
- Monitor and evaluate effectiveness of pain medications in relieving resident's pain using pain scale in the vitals section of the electronic documentation
- Consider initiating Pain Study Tool for 24 hours or longer to assist with the assessment and evaluation of pain management when pain remains regardless of interventions; a scheduled pain medication regimen does not relieve pain
- Evaluate plan of care for effectiveness and revise as needed

On a specified date, Inspector #672 observed resident #041 in a room calling out as well as rocking back and forth while in a mobility device. Inspector #672 reported the observation to the RPN on the unit, who indicated that the resident had received the routine pain medications, and was not due for anything else at the time. The RPN indicated to Inspector #672, that the resident would receive more medications when` they were due. On the same day, Inspector #672 passed the concern onto the DOC, who indicated that resident #041 had as needed medications (PRN) available but the RPNs did not feel comfortable giving a PRN at the same time, or soon after, a routine medication.

Inspector #461 reviewed resident #041's electronic Medication Administration Records

(eMAR) for a specified month. during this review, it was identified that resident received the routine pain medications at a specified hour. Inspector #461 identified that a pain assessment was not completed and PRN medications was not administered to the resident on a specified date.

Inspector #461 reviewed resident #041's clinical records and identified recommendations from a consultant, that was documented on a previous specified date, in relation to the progression of the resident`s diagnosis. The recommendations included suggestions for pain management.

Inspector #461 reviewed resident #041's most recent Medication Review Report with orders for a specified three month period, which listed the prescribed routine and PRN pain medications.

Review of resident #041's physician assessment on a specified date, indicated that the resident was displaying a specified responsive behaviour. The physician ordered pain medication for the resident on the same specified date. A pain assessment was not completed for the resident on this date.

Inspector #461 reviewed the pain assessments for resident #041 for a specified seven months period in which four assessments were completed. These assessments were done in four separate months. Personal Support Worker #107 indicated to Inspector #672, that staff would leave the resident to sleep in later in the mornings due to the resident's struggle with good pain control.

During separate interviews with RPN #125 and the DOC, both indicated to Inspector #461 that if a resident is on pain medications, the registered staff must complete a weekly pain management assessment that is located in the home's electronic documentation system. The RPN indicated, that the resident must be referred to the physician or Nurse Practitioner (NP) as needed. The RPN also acknowledged that the weekly assessments had not been completed for resident #041. The RPN also indicated, that the assessments should had been done as the resident often struggled with pain. The RPN indicated, that prior to the interview with the Inspector, it was intended to refer resident #041 to the NP for an assessment as the resident had been displaying identified responsive behaviours. The RPN was uncertain, whether the resident's behaviours were related to pain.

The DOC indicated to inspector #461 that the home's pain management program

included a pain management assessment to be completed on admission; a weekly pain management assessment if a resident is on routine pain medications or had required any PRN pain medications; quarterly pain assessments if it triggers through the MDS assessments; if a resident is using frequent PRNs, based on the weekly assessment and there should be a referral to the NP or physician. The DOC further confirmed, that the pain management program was not followed for resident #041.

The licensee failed to ensure that its policy for "Pain Management" (#VII-G-30.10), was complied with, specifically related to monitoring and evaluating effectiveness of pain medications in relieving resident's pain using the electronic pain assessments. [s. 8. (1) (a),s. 8. (1) (b)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that an allegation of staff to resident abuse and neglect was immediately reported to the Director.

Resident #020 informed Inspector #672 of being involved in an incident with PSW #110, in which the resident felt that the PSW had spoken to the resident in a rude and demeaning way. The PSW had also refused to provide assistance with transportation for the resident to attend the dining room for a meal. Resident #020 further indicated, that on this specified date a spill occurred in the resident's room. The housekeeping staff was informed by the charge nurse, who stated housekeeping would be in to clean the area in a few minutes. Resident #020, then requested PSW #110's assistance to get to the dining room for the meal service. According to resident #020, PSW #110 stated in a harsh tone that the resident had to wait in the bedroom until the spill was cleaned up. Resident #020 further indicated, that an explanation was provided to the PSW that the resident was feeling hungry that morning and was concerned about missing the meal service. Resident #020 indicated, that PSW #110's response was that the resident will just have to wait and refused to provide assistance with transportation to the dining room. Resident #020 indicated having cleaned up the spill, in the hope that this would persuade PSW #110, to provide assistance to the dining room. The PSW continued to refuse assistance to the resident with transportation until the housekeeping staff arrived. The resident indicated that the home's management team was not informed of the incident.

Following the interview with resident #020, Inspector #672 immediately informed the DOC of resident #020's allegations.

On another specified date, Inspector #672 approached the DOC and inquired if the Director had been notified of resident #020's allegations. The DOC informed Inspector #672, that the Director had not been notified of resident #020's allegations.

The team exited the home on a specified date and at that time, the Director had not been notified of resident #020's allegations. [s. 24. (1)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of bed rails as a PASD for resident #017 has been approved by
i. a physician
ii. a registered nurse
iii. a registered practical nurse
iv. a member of the College of Occupational Therapists of Ontario
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.

4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

2007, c. 8, s. 33 (4).

Related to resident #017

On a specified date, Inspector #570 observed resident #017 in bed with two bed rails in use. Review of MDS assessments since admission also indicated that the resident used bed rails daily.

Review of current plan of care reviewed on a specified date, for resident #017 indicated the two bed rails used for the resident are considered as Personal Assistance Services Device (PASD).

During an interview RPN # 128 indicated to Inspector #570, that resident #017 uses bed rails as a PASD for bed mobility and that the resident has had the bed rails since moving into the home. The RPN indicated not being able to find any documentation indicating that the use of the bed rails as a PASD had been approved by the physician or the physiotherapist.

The licensee failed to ensure that the use of bed rails as a PASD for resident #017 has been approved by the physician or physiotherapist. [s. 33. (4) 3.]

2. The licensee has failed to ensure that the use of bed rails as a PASD for resident #017 has been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

On a specified date, during an interview, RPN #128 indicated to Inspector #570 that resident #017 uses bed rails as a PASD for bed mobility and that the resident had the bed rails since moving into the home. The RPN indicated not being able to find any documentation indicating that the resident or the resident's Substitute Decision Maker (SDM) consented for the use of the bed rails as PASD.

The licensee failed to ensure that the use of bed rails as a PASD for resident #017 has been consented to by the resident or, if the resident was incapable, a substitute decision-maker. [s. 33. (4) 4.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident 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.

Related to Log #022061-17 for resident #007

A review of the resident's medical records specifically the home's electronic documentation system for a one month period, indicated that the resident received two baths in this period. The electronic documentation system indicated, that the resident was provided a bath on two specified dates within the specified one month period and refused a bath on another specified date. There was also documentation to indicate "not applicable" on four other specified dates.

A review of resident #007's current written care plan, outlined interventions for bathing and that this should take place on two separate specific days in a week.

A review of the resident home area bath schedule on a specified date, indicated that the resident`s bath days were scheduled on two other specified dates, than indicated in the plan of care.

In an interview, the resident denied refusing baths and indicated not having many baths, as the staff may have been busy. The resident also mentioned having a bath few days before the interview. The resident did indicate that on another specified date, that staff provided a bath in bed when a tub bath or a shower was not provided.

During an interview with PSW #127, the PSW indicated that when the bath days changed, it was not updated in the home's electronic software and not applicable was

documented on the scheduled days that were incorrect. When the bath was provided on another day, it was documented under the PRN section in the electronic software. The PSW also indicate that the charge nurse was informed and the bath days were corrected.

In another interview, RN #126 indicated that the resident's bath days were to take place on two specified days. The scheduled bath days for the resident were noted in the written care plan to be on two different specified days from the days indicated by the RN. The RN also indicated that at the time of the interview, the current bath schedule and designated days on the plan of care were corrected and were accurate

The licensee failed to ensure that resident #007 was bathed, at a minimum, twice a week by the method of the resident's choice. Resident #007 received two baths during a period of one month. There was no documented evidence to support that the resident was given any other baths. The current written care plan directs the documentation of when the resident received or refused to have a bath and this information was not consistently recorded. [s. 33. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #020's Substitute Decision Maker (SDM) was notified within 12 hours, upon becoming aware of an allegation of staff to resident abuse or neglect.

Related to #020

Resident #020 informed Inspector #672 of being involved in an incident with PSW #110, in which the resident felt that the PSW had spoken to the resident in a rude and demeaning way. The PSW had also refused to provide assistance with transportation for the resident to attend the dining room for a meal. Resident #020 further indicated, that on this specified date, a spill occurred in the resident's room. The housekeeping staff was informed by the charge nurse, who stated housekeeping would be in to clean the area in a few minutes. Resident #020, then requested PSW #110's assistance to get to the dining room for the meal service. According to resident #020, PSW #110 stated in a harsh tone that the resident had to wait in the bedroom until the spill was cleaned up. Resident #020 further indicated, that an explanation was provided to the PSW that the resident was feeling hungry that morning and was concerned about missing the meal service. Resident #020 indicated PSW #110's response was that the resident will just have to wait and refused to provide assistance with transportation to the dining room. Resident #020 indicated having cleaned up the spill, in the hope that this would persuade PSW #110, to provide assistance to the dining room. The PSW continued to refuse assistance to the resident with transportation, until the housekeeping staff arrived. The resident indicated that the home's management team was not informed of the incident.

During an interview resident #020, indicated forgetting to mention the incident to the SDM. Immediately following this interview, Inspector #672 informed the DOC of resident #020's allegations.

On another specified date during an interview, the DOC indicated that the SDM for resident #020 had not been notified of the allegation of staff to resident abuse and neglect, brought forth by resident #020 on a previous specified date.

The licensee failed to ensure that resident #020's SDM was notified within 12 hours, upon becoming aware of an allegation of staff to resident abuse. [s. 97. (1) (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure the report to the Director included the following description of the individuals involved with the incident, specifically did not include,

ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.

Related to Log #021534-17 for resident #050

A Critical Incident Report (CIR) was submitted to the Director for a fall that resulted in an injury to a resident. The resident #050 was taken to hospital because of the injury, which also resulted in a significant change in the resident's health status.

During an interview, resident #050 indicated to Inspector #570 of receiving assistance from the nurse and PSWs after the fall.

Inspector #570 interviewed the DOC, who indicated that the PSW staff discovered the resident after the fall and alerted the nurse. The DOC further indicated, not including the names of the PSW staff who discovered the resident and the names of PSW staff who comforted the resident.

The licensee failed to ensure the report to the Director following resident #050's fall, included the names of the staff who were present and discovered or responded to the incident. [s. 107. (4) 2.]

Issued on this 12th day of January, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DENISE BROWN (626), CRISTINA MONTOYA (461), JENNIFER BATTEN (672), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2017_623626_0016
Log No. / No de registre :	019232-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 6, Dec 8, 2017
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Case Manor Care Community 28 BOYD STREET, P.O. BOX 670, BOBCAYGEON, ON, K0M-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Monica Cara

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Immediately following the receipt of this Compliance Order, the Licensee shall:

1. Ensure that each resident is offered a minimum of three meals daily, including breakfast.

2. Develop and implement an auditing tool to ensure that each resident is receiving a minimum of three meals daily. The auditing tool must include: residents who attend dining room meal service; residents who receive tray service; residents who do not attend the dining room meal service and the reason for the resident's refusal of the offered meal, regardless of location. The audit will be carried out for at least four consecutive days and include all three meals.

3. Review and analyze the audit results following each audited meal to ensure actions are taken as needed to meet the nutritional needs of all residents, with a particular focus on residents at moderate to high nutritional risk and those participating in the Late Riser Continental Breakfast program.

All parts of this order are to be complied by October 11, 2017

Grounds / Motifs :

1. The licensee has failed to ensure that all residents are offered a minimum of

three meals daily, specifically the breakfast meal.

On a specified date during an interview, resident #020 indicated to Inspector #672, that there were some mornings that the resident did not receive breakfast. The resident also indicated that on specified occasions being served a drink and snack when breakfast was not provided.

The home has a number of resident home areas each with separate dining rooms. Inspector #672 observed the breakfast meal service in all dining rooms on four separate dates and noted the following;

Inspector #672 observed the breakfast meal service on a specified date in all dining rooms within the home, and made the following observations:

On the same specified date on an identified resident home area, Inspector #672 observed that residents #014, #016, #020 and #041 were not in the dining room for breakfast. During an interview Personal Support Worker (PSW) #107 indicated that only one of the identified residents preferred to sleep in late in the mornings.

PSW #107 indicated, that resident #020 did not attend the dining room on an identified date and a tray was provided to the resident.

PSW #108 indicated that resident #014 was sleeping and had refused breakfast, which was verified by the Inspector. PSW #108 also indicated that the resident would receive a drink and snack later that morning.

In another identified resident home area and on the same date, Inspector #672 observed that residents #049 and #031 were not in the dining room for breakfast.

On a different identified resident area on the same specified date Inspector #672 observed that residents #001, #006, #047 and #046, did not attend the dining room for breakfast. PSW #119 indicated, that the residents would receive fluids and a snack but when it was offered resident #001 refused.

In an interview with Inspector #672, the Food Service Worker (FSW) #120 indicated, that it is acceptable for residents to go into the dining room for breakfast in their house coats and/or pyjamas. The FSW further added that if

the residents were not comfortable with attending breakfast in the dining room wearing their house coats and/or pyjamas, they would be provided with cereal as an alternative at a specified time.

Inspector #672 interviewed the Director of Care (DOC), regarding the breakfast meal observations which were made. The DOC indicated being aware of the fact that some residents were missing the breakfast meal and this was a previous complaint from some residents and family members. DOC further indicated, that it was acceptable for residents to attend the dining room in their housecoats and/or pyjamas, if the residents were comfortable with that decision, and it was never acceptable for a resident to miss attending a meal due to a staffing concern. The DOC indicated that even if staff were running out of time, that it should always be the resident's choice and at a minimum, the residents should receive a continental breakfast meal, if they were not able to arrive to the dining room before the breakfast meal was completed.

Inspector #672 observed the breakfast meal on a second specified date, in all dining rooms within the home and made the following observations:

Observations by Inspector #672 of the breakfast meal on an identified resident home area, indicated that residents #014, #026 and #051, did not attend the dining room for breakfast. During an interview, PSW #129 indicated that residents #014, #026 and #051 were left in bed, as it was in each resident's written plan of care to remain in bed until after the breakfast meal. PSW #129 further indicated, that the residents would not receive tray service or be brought to the dining room following the dining service for a continental breakfast, but the residents would receive fluids and a snack after the breakfast service.

Observations by Inspector #672 of the breakfast meal on another identified resident home area, indicated that residents #049 and #031 did not attend the dining room for breakfast. During an interview, PSW #129 indicated, that the residents did not attend the breakfast meal that morning due to staff running out of time, and could not provide personal care prior to breakfast. PSW #129 further indicated, that the residents would not receive tray service but would receive fluids and a snack after the breakfast service.

Observations by Inspector #672 of the breakfast meal on a different resident home area indicated, that residents #009, #006, #010, #052, #012, #053 and #054, did not attend the dining room for the breakfast meal. During an interview,

PSW #119 indicated that only one of the identified residents, who did not attend the dining room would not receive tray service but would receive fluids and a snack after the breakfast service.

Inspector #672 observed the breakfast meal on a third specified date, in all dining rooms within the home and made the following observations:

Observations by Inspector #672 of the breakfast meal on an identified resident home area indicated, that residents #015, #028, #055, #051, #019 and #056, did not attend the dining room for the breakfast meal. During an interview, PSW #107 indicated that residents #015, #028, #055, #051 and #019 were all sleeping, therefore staff did not awaken them to attend the dining room for breakfast, and resident #056 only attended the dining room for breakfast when the resident desired. PSW #107 further indicated, that the residents would not receive trays but would receive fluids and a snack after the breakfast service.

Observations by Inspector #672 of the breakfast meal on another identified resident home area, revealed residents #057, #049, #039, #048 and #031 did not attend the dining room. During an interview, PSW #131 indicated that resident #057 did not attend the dining room for the breakfast meal, as the resident had been noted to be sleeping soundly and staff did not want to awaken the resident. The PSW also indicated, that resident #049 had not been feeling well. During an interview, PSW #132 indicated, that resident #039 did not attend the dining room as the transfer device in the resident's room was not working, therefore the resident could not be transferred out of bed. The PSW also indicated, that resident #031 did not attend the dining room as the PSW had run out of time to provide the resident with assistance.

Observations by Inspector #672 of the breakfast meal on a different resident home area, revealed that residents #001, #004, #005, #006, #010, #011, #046, #047, #052, #058, #059 and #060, did not attend the dining room for the breakfast meal. During an interview PSW #119 indicated, that residents #006, #010 and #011, did not attend the dining room, as the PSW had run out of time to provide the residents with assistance prior to the breakfast meal. PSW #119 further indicated, that the residents would not receive tray service but would receive fluids and a snack after the breakfast service.

Inspector #672 observed the breakfast meal on a fourth specified date and made the following observations:

Observations by Inspector #672 of the breakfast meal on an identified resident home area, revealed that residents #051, #055, #019, #014 and #041 did not attend the dining room for breakfast. During an interview, PSW #107 indicated that all of the residents who did not attend the dining room had been noted to be sleeping soundly that morning, therefore staff did not want to awaken them. The PSW further indicated, that the residents who did not attend the dining room for breakfast would not receive a continental breakfast meal but would receive fluids and a snack after the breakfast service.

Observations by Inspector #672 of the breakfast meal on an identified resident home area, revealed that resident #039 did not attend the dining room, as the resident was sleeping. During an interview, PSW #132 indicated that the resident would not receive a continental breakfast upon awakening, but would receive fluids and a snack after the breakfast service.

Observations by Inspector #672 of the breakfast meal on a different resident home area, revealed that residents #001, #002, #006, #007, #011, #047 and #053, did not attend the dining room for breakfast. During an interview, PSW #138 indicated that all residents who did not attend the dining room had been noted to be sleeping, except residents #001 and #002, who refused to attend the dining room that morning. PSW #138 further indicated, that the residents who did not attend the dining room for breakfast that morning would not be served a continental breakfast, but would receive fluids and a snack after the breakfast service.

On the first specified date, Inspector #672 interviewed the Registered Dietitian (RD), who indicated that the dietary services is expected to offer the residents a "Late Riser Continental Breakfast", which was available to all residents up to 1000 hours daily. If residents were not arriving to the dining room on time to have the regular breakfast meal, the continental meal should be offered to the resident, which consisted of cold cereal, toast, a hot drink and a cold drink, which would be prepared by the PSW nursing staff. The RD further indicated, that it should always be the resident's choice, whether or not they attend the dining room for the breakfast meal service. This decision should not be impacted by staffing issues, such as running out of time or related to the bathing schedule. It was also an acceptable option for the residents to attend the dining room in their housecoat and/or pyjamas, if the resident desired and was comfortable.

On the fourth specified date, Inspector #461 interviewed the Director of Dietary Services (DDS), who indicated not having been aware that there were residents in the home who were not consistently receiving a breakfast meal, either in the dining room, or the resident's room. The DDS further indicated, that the expectation was that residents who were noted to be early risers (awakening at a specified time) were to be offered a continental breakfast which contained cold cereal, milk, toast, tea and coffee, if they were hungry and requesting a meal before the breakfast service. For the residents who chose to sleep in, the expectation was that the residents were to be offered a continental breakfast up to 1000 hours. After that 1000 hours, the residents were to receive a beverage, along with an assortment of cookies or the staff could access muffins from the servery, if the residents preferred.

The licensee has failed to ensure that all residents are offered a minimum of three meals daily, specifically the breakfast meal. [s. 71. (3) (a)]
(626)

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall ensure:

1. At least one Registered Nurse (RN), who is both an employee of the licensee and a member of the regular nursing staff of the home, is on duty and present in the home at all times.

2. Provide documented evidence to demonstrate that a backup RN staffing plan has been implemented, in accordance with the legislative requirements under O. Reg 79/10 s.45.

3. Provide documented evidence to demonstrate recruitment and retention has been completed for any planned and/or extended leave.

4. Provide documented evidence that the Corporate Office has been notified of any RN staffing concerns.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one Registered Nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times, except as provided for in the Regulations.

O. Reg 79/10 s.45(2)(i)(ii)(A)(B) for 24 hour nursing care – exemptions;

For a home with a licensed bed capacity of more than 64 beds and fewer than 129 beds,

-in the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used,

-in the case of an emergency where the back-up plan referred to in clause 31(3)(d) of this regulation fails to ensure that the requirement under subsection 8(3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third part may be used if,

-The Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and

-a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

According to O.Reg. 79/10, s.45(1) the definition of an "emergency" is as follows:
"Emergency means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the long-term care home."

The home has a licensed bed capacity of ninety-six beds.

During an interview on a specified date, the DOC indicated that the licensee was struggling with recruitment and retention of Registered Nursing staff. Due to frequent struggles to fill Registered Nurse (RN) shifts, the licensee maintained contracts with two separate nursing staff support agencies. The DOC further indicated, that there had been vacant RN shifts on the schedule over the previous three months, when the licensee had been unable to fill the shifts with RN staff members of the home and the agencies were unable to provide a Registered Nurse. This lead to the home operating without an RN on duty.

On a specified date, Inspector #672 was provided with a copy of the home staffing plan, along with the RN staff schedules for a specified time period. Review of the RN staff schedules for the specified time period, identified that there were a number of shifts where the home did not have an RN present and

on duty.

During an interview on a specified date, the DOC indicated that on the dates when an RN was not present and on duty in the home, no emergencies had occurred to prevent the RN from attending the vacant shift.

The licensee failed to ensure that at least one Registered Nurse, who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times, during the identified period, when there were a number of shifts where the home did not have an RN present and on duty. [s. 8. (3)] (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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

Issued on this 6th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Denise Brown

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