Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 8, 2019	2019_657681_0007	002569-19, 002632-19	Follow up

Licensee/Titulaire de permis

Valley East Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Elizabeth Centre
2100 Main Street Val Caron ON P3N 1S7

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

STEPHANIE DONI (681), AMY GEAUVREAU (642)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 18 - 22, 2019, and March 25 - 29, 2019.

The following intakes were inspected on during this Follow up inspection:

- One intake related to compliance order (CO) #001 that was issued during inspection #2019_679638_0001 for s. 11 (2) of the Long-Term Care Homes Act (LTCHA), specific to the home ensuring that residents were provided with food and fluids that were safe, adequate in quantity, nutritious, and varied.

- One intake related to CO #001 that was issued during inspection #2019_679638_0002 for s. 8 (1) (b) of the LTCHA, specific to the home ensuring that there was an organized program of personal support services to meet the assessed needs of residents.

A Critical Incident inspection #2019_657681_0008, a Complaint inspection #2019_657681_0009, and an Other inspection #2019_657681_0010 were conducted concurrently with this inspection.

PLEASE NOTE: Non-compliance related to s. 8 (1) (b) of the LTCHA, 2007, was identified in concurrent inspections #2019_657681_0008 and #2019_657681_0009, and was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Care Service Coordinator, Director of Care (DOC), Co-Directors of Care (Co-DOC), Regional Culinary Manager, Food Service Manager, Registered Dietitian (RD), Staff Educators, Restorative Care Coordinator, Staffing Coordinator, Life Enrichment Staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Supports Ontario (BSO) RPN, Personal Support Workers (PSWs), Cooks, Dietary Aides, family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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
LTCHA, 2007 S.O. 2007, c.8 s. 11. (2)	CO #001	2019_679638_0001	681

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

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

During Inspection #2019_679638_0002, CO #001 was issued to the home, which ordered the licensee to be compliant with s. 8 (1) (b) of the LTCHA, 2007.

Specifically, the licensee was ordered to:

a) ensure that the organized program of personal support services for the home met the assessed needs of the residents;

b) develop and implement a plan to ensure that when residents required a specific intervention, that the assigned staff member was aware of their responsibilities and was not pulled from their duties; and

c) maintain a record to monitor when a resident had the specific intervention implemented and who provided the monitoring, for every resident who required the specific intervention.

The compliance due date of this order was March 6, 2019.

While the licensee complied with section "c)", non-compliance continued to be identified with section "a)" and "b)", where the licensee was directed to ensure that the organized program of personal support services met the assessed needs of the residents and where the licensee was to ensure that when a specific intervention was required, the assigned staff member was aware of their responsibilities and was not pulled from their duties.

A) Inspector #642 reviewed resident #003's plan of care and identified that resident #003 had a specified intervention in place.

The Inspector reviewed the progress notes in resident #003's health care record and identified two progress notes that were entered on two particular dates. The progress notes indicated that the resident did not have the specified intervention in place on either of these dates. The Inspector also identified progress notes from two additional dates, which indicated that staff had implemented an alternate intervention for resident #003,

which was different from the intervention outlined in the resident's plan of care.

The Inspector reviewed a particular document for resident #003, which identified that the resident did not have the specified intervention in place on seven different dates.

During an interview with RPN #108, they stated that resident #003 required the specified intervention. RPN #108 stated that when the Home Area was short PSWs, there would not be a staff member available to implement the specified intervention for resident #003.

During separate interviews with RN #117 and RN #125, they stated that resident #003 required the specified intervention and that when the home area was short staffed, there would not be a specific staff member to implement the specified intervention.

The Inspector reviewed the home's policy titled, "Resident Rights, Care and Services-Nursing and Personal Support Services-Staffing Plan," which indicated that the written staffing plan included a staffing mix that was consistent with residents' assessed care and safety needs and which met the requirements set out in the Act and Regulation.

Inspector #642 interviewed Co-DOC #102, who stated that resident #003 was supposed to have the specified intervention in place at all times, but that there was not always a staff member available to implement the specified intervention.

B) A Critical Incident System (CIS) report was submitted to the Director related to an incident that involved two residents. The CIS report indicated that, on a particular date, an incident occurred involving resident #003 and resident #013 and that resident #003 did not have a specified intervention in place at the time of the incident.

The Inspector reviewed a particular document for resident #003, which identified that the resident did not have the specified intervention in place on the date the incident occurred.

The Inspector reviewed resident #003's health care record and identified progress notes entered by BSO RPN #121 and RN #125. The progress notes indicated that resident #003 did not have the specified intervention in place when the incident occurred because the Home Area was short staffed at the time.

During an interview with PSW #124, they stated that they witnessed the incident that occurred involving resident #003 and resident #013. PSW #124 stated that resident #003 did not have the specified intervention in place when the incident occurred because the

Home Area was short staffed on this date.

During an interview with RPN #108, they stated that when the Home Area was short staffed, the specified intervention was not always implemented for resident #003. RPN #108 identified that when the incident occurred, the home was short staffed and resident #003 did not have the specified intervention in place.

The Inspector interviewed Co-DOC #102, who stated that resident #003 required the specified intervention, but that this intervention was not in place when the incident occurred.

2. Two complaints were submitted to the Director related to residents not receiving their bathing choice due to insufficient staffing.

Inspector #642 reviewed a document titled “Daily Home Area Record” for a specified Home Area that was dated a particular date in March 2019. The document indicated that resident #015 did not receive their bathing choice on this particular date.

Inspector #642 reviewed the “Assignment Sheet” for the specified Home Area, which indicated that resident #015 was to receive their bathing choice on two specified days each week. The Inspector reviewed the Point of Care (POC) documentation and identified that on the particular date, resident #015's bathing choice was marked as “not applicable”.

During interviews with PSW #137, RPN #136, and RN #117, they indicated that documentation related to the provision of the bathing choice would be in the POC, on the “Daily Home Area Record”, or in a progress note in the resident's health care record. PSW #137, RPN #136, and RN #117 stated that if a bathing choice was missed, a “Bath Audit Form” was to be completed and submitted to one of the Co-DOCs.

Inspector #681 reviewed the progress notes in resident #015’s health care record for a specified period in March 2019, and was unable to identify any progress notes related to bathing.

Inspector #642 reviewed a “Bath Audit Form” completed by PSW #123 for the specified Home Area on the particular date. The "Bath Audit Form" indicated that resident #015's bathing choice was not completed on the particular date because the unit was short staffed and there was not enough time to complete the bathing choice.

During an interview with the Staffing Coordinator, they stated that, on the particular date, the home was short four PSWs on a specified shift.

During an interview with PSW #123, they stated that the specified Home Area was short staffed on the particular date, and that they were not able to complete resident #015's bathing choice. PSW #123 stated that they documented resident #015's missed bathing choice on a "Bath Audit Form".

B) During an interview with Inspector #681, resident #005's family member stated that resident #005 was not receiving their scheduled bathing choice because the home was short staffed.

Inspector #642 reviewed the "Assignment Sheet" for a specified Home Area, which identified that resident #005 was to receive their bathing choice on two specified days each week. The Inspector reviewed the POC documentation and identified that resident #005's bathing choice was documented as "not applicable" on one particular date in March and that there was no documentation for the resident's bathing choice on two additional dates in March 2019.

Inspector #681 reviewed the progress notes in resident #005's health care record for a specified period in March 2019, and was unable to identify any progress notes in the health care record related to bathing.

During an interview with the Staffing Coordinator, they identified that on one of the particular dates, the home was short two PSWs on a specified shift, and that on the two additional dates, the home was short four PSWs on a specified shift.

During an interview with PSW #137, they stated that they worked in the specified Home Area on a particular date in March 2019. PSW #137 stated that they were not assigned to complete resident #005's bathing choice, but that they recalled that resident #005's bathing choice was not completed. The Inspector then spoke with PSW #139, who stated that they were assigned to provide resident #005 their bathing choice, but that they did not complete the bathing choice because it was supposed to be completed on another day of the week. PSW #137 stated that they documented the bathing choice as "not applicable". The Inspector verified that there was no documentation to indicate that the resident's bathing choice was completed on the other day of the week.

During an interview with PSW #114, they stated that they were assigned to complete resident #005's bathing choice on two specified dates in March 2019. PSW #114 stated that when the home was short staffed, they could not always complete the assigned resident's bathing choice. PSW #114 stated that they could not recall if resident #005's bathing choice was completed on the two specified dates, but PSW #114 stated that if they had completed the resident's bathing choice, they would have documented it in the POC.

C) During an interview with Inspector #681, resident #014 stated that they had missed their bathing choice on a particular date in March 2019, because the home was short staffed. Resident #014 stated that the missed bathing choice had not been completed on another shift.

Inspector #642 reviewed the "Assignment Sheet" for a specified Home Area, which indicated that resident #014 was to receive their bathing choice on two specified dates each week. The Inspector reviewed the POC documentation and identified that on the particular date, there was no documentation to indicate that resident #014 received their bathing choice.

Inspector #681 reviewed the progress notes in resident #014's health care record for a specified period of time in March 2019. The Inspector did not identify any progress notes related to bathing.

Inspector #642 reviewed the "Daily Home Area Record" for the specified Home Area and identified that there was nothing written on the document related to resident #014's bathing choice on the particular date.

During an interview with the Staffing Coordinator, they stated that, on the particular date, the home was short three PSWs on a specified shift.

During an interview with PSW #140, they stated that the specified Home Area was short staffed on the particular date. PSW #140 stated that when the Home Area was short staffed, they had to make decisions about which resident's bathing choice to complete, taking into consideration which residents had already received their bathing choice that week. PSW #140 stated that resident #014's bathing choice was not given on the particular date, because the home area was short staffed and the resident had already received their bathing choice that week.

During an interview with PSW #115, they stated that every time the home was short staffed, there were residents who did not receive their bathing choice. PSW #115 stated that residents who were not cognitive were more likely to have their bathing choice missed compared to residents who were cognitive or residents who had family members that were frequently present in the home.

D) Inspector #681 reviewed resident #013's health care record and identified a progress note that was created by RPN #130 on a particular date in March 2019. The progress note indicated that resident #013 was given a different bathing choice instead of their scheduled bathing choice.

The Inspector reviewed the "Assignment Sheet" from a specified Home Area, which identified that resident #013 was to receive their bathing choice on two specified dates each week.

The Inspector reviewed the POC for resident #013 and identified that resident #013's bathing choice was signed as completed on the particular date in March 2019.

During an interview with RPN #130, they stated that on the particular date, the specified Home Area was short staffed and that, for a portion of the shift, the Home Area only had two PSWs. RPN #130 stated that resident #013 was supposed to get their bathing choice on the particular date, but their bathing choice was not completed because the Home Area was short staffed and staff "just could not get [the resident's bathing choice] done". RPN #130 stated that, of the five residents who were supposed to receive their bathing choice on that day, only two residents received their bathing choice.

During interviews with PSW #131 and PSW #132, they stated that when a resident was given a specific type of bathing choice, it would be documented in the POC as completed, even if the resident was supposed to receive a different bathing choice. PSW #131 and PSW #132 stated that they were unable to get a resident's bathing choice done when the Home Area was short staffed.

During an interview with PSW #123, they also stated that residents were being given a specific type of bathing choice instead of their selected bathing choice because the home had been short staffed. PSW #123 stated that staff were documenting the resident's bathing choice as completed when the resident was provided with a bathing choice contrary to their wishes.

The Inspector interviewed Co-DOC #102 and Co-DOC #103, who stated that the provision of personal care, such as the resident's bathing choice, must be documented in order to know that the bathing choice was completed. Co-DOC #102 and Co-DOC #103 stated that if staff were unable to complete the resident's bathing choice then a "Bath Audit Form" was supposed to be filled out. [s. 8. (1) (b)]

Additional Required Actions:

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

Issued on this 9th day of April, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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) :	STEPHANIE DONI (681), AMY GEAUVREAU (642)
Inspection No. / No de l'inspection :	2019_657681_0007
Log No. / No de registre :	002569-19, 002632-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 8, 2019
Licensee / Titulaire de permis :	Valley East Long Term Care Centre Inc. c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
LTC Home / Foyer de SLD :	Elizabeth Centre 2100 Main Street, Val Caron, ON, P3N-1S7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantal Carriere

To Valley East Long Term Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_679638_0002, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,

(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and

(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) (b) of the LTCHA, 2007.

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

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

a) how the licensee will ensure that when residents require a specified intervention, that the assigned staff member is aware of their responsibilities and not pulled from their duties;

b) how the licensee will 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;

c) how the licensee will develop and implement a process to ensure that documentation is maintained when a resident's bathing choice is not completed as scheduled, or if a resident is bathed using a method other than their preferred choice, as outlined in the resident's plan of care.

Please submit the written plan, quoting Inspection #2019_657681_0007 and Inspector Stephanie Doni, by email to SudburySAO.moh@ontario.ca by April 25, 2019.

Please ensure that the submitted written plan does not contain any personal information or personal health information.

Grounds / Motifs :

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

During Inspection #2019_679638_0002, CO #001 was issued to the home, which ordered the licensee to be compliant with s. 8 (1) (b) of the LTCHA, 2007.

Specifically, the licensee was ordered to:

a) ensure that the organized program of personal support services for the home met the assessed needs of the residents;

b) develop and implement a plan to ensure that when residents required a specific intervention, that the assigned staff member was aware of their responsibilities and was not pulled from their duties; and

c) maintain a record to monitor when a resident had the specific intervention implemented and who provided the monitoring, for every resident who required the specific intervention.

The compliance due date of this order was March 6, 2019.

While the licensee complied with section "c)", non-compliance continued to be identified with section "a)" and "b)", where the licensee was directed to ensure that the organized program of personal support services met the assessed needs of the residents and where the licensee was to ensure that when a specific intervention was required, the assigned staff member was aware of their responsibilities and was not pulled from their duties.

A) Inspector #642 reviewed resident #003's plan of care and identified that resident #003 had a specified intervention in place.

The Inspector reviewed the progress notes in resident #003's health care record and identified two progress notes that were entered on two particular dates. The progress notes indicated that the resident did not have the specified intervention in place on either of these dates. The Inspector also identified progress notes from two additional dates, which indicated that staff had implemented an alternate intervention for resident #003, which was different from the intervention outlined in the resident's plan of care.

The Inspector reviewed a particular document for resident #003, which identified that the resident did not have the specified intervention in place on seven different dates.

During an interview with RPN #108, they stated that resident #003 required the

specified intervention. RPN #108 stated that when the Home Area was short PSWs, there would not be a staff member available to implement the specified intervention for resident #003.

During separate interviews with RN #117 and RN #125, they stated that resident #003 required the specified intervention and that when the home area was short staffed, there would not be a specific staff member to implement the specified intervention.

The Inspector reviewed the home's policy titled, "Resident Rights, Care and Services-Nursing and Personal Support Services-Staffing Plan," which indicated that the written staffing plan included a staffing mix that was consistent with residents' assessed care and safety needs and which met the requirements set out in the Act and Regulation.

Inspector #642 interviewed Co-DOC #102, who stated that resident #003 was supposed to have the specified intervention in place at all times, but that there was not always a staff member available to implement the specified intervention.

B) A Critical Incident System (CIS) report was submitted to the Director related to an incident that involved two residents. The CIS report indicated that, on a particular date, an incident occurred involving resident #003 and resident #013 and that resident #003 did not have a specified intervention in place at the time of the incident.

The Inspector reviewed a particular document for resident #003, which identified that the resident did not have the specified intervention in place on the date the incident occurred.
The Inspector reviewed resident #003's health care record and identified progress notes entered by BSO RPN #121 and RN #125. The progress notes indicated that resident #003 did not have the specified intervention in place when the incident occurred because the Home Area was short staffed at the time.

During an interview with PSW #124, they stated that they witnessed the incident that occurred involving resident #003 and resident #013. PSW #124 stated that

resident #003 did not have the specified intervention in place when the incident occurred because the Home Area was short staffed on this date.

During an interview with RPN #108, they stated that when the Home Area was short staffed, the specified intervention was not always implemented for resident #003. RPN #108 identified that when the incident occurred, the home was short staffed and resident #003 did not have the specified intervention in place.

The Inspector interviewed Co-DOC #102, who stated that resident #003 required the specified intervention, but that this intervention was not in place when the incident occurred.

2. Two complaints were submitted to the Director related to residents not receiving their bathing choice due to insufficient staffing.

Inspector #642 reviewed a document titled "Daily Home Area Record" for a specified Home Area that was dated a particular date in March 2019. The document indicated that resident #015 did not receive their bathing choice on this particular date.

Inspector #642 reviewed the "Assignment Sheet" for the specified Home Area, which indicated that resident #015 was to receive their bathing choice on two specified days each week. The Inspector reviewed the Point of Care (POC) documentation and identified that on the particular date, resident #015's bathing choice was marked as "not applicable".

During interviews with PSW #137, RPN #136, and RN #117, they indicated that documentation related to the provision of the bathing choice would be in the POC, on the "Daily Home Area Record", or in a progress note in the resident's health care record. PSW #137, RPN #136, and RN #117 stated that if a bathing choice was missed, a "Bath Audit Form" was to be completed and submitted to one of the Co-DOCs.

Inspector #681 reviewed the progress notes in resident #015's health care record for a specified period in March 2019, and was unable to identify any progress notes related to bathing.

Inspector #642 reviewed a "Bath Audit Form" completed by PSW #123 for the specified Home Area on the particular date. The "Bath Audit Form" indicated that resident #015's bathing choice was not completed on the particular date because the unit was short staffed and there was not enough time to complete the bathing choice.

During an interview with the Staffing Coordinator, they stated that, on the particular date, the home was short four PSWs on a specified shift.

During an interview with PSW #123, they stated that the specified Home Area was short staffed on the particular date, and that they were not able to complete resident #015's bathing choice. PSW #123 stated that they documented resident #015's missed bathing choice on a "Bath Audit Form".

B) During an interview with Inspector #681, resident #005's family member stated that resident #005 was not receiving their scheduled bathing choice because the home was short staffed.

Inspector #642 reviewed the "Assignment Sheet" for a specified Home Area, which identified that resident #005 was to receive their bathing choice on two specified days each week. The Inspector reviewed the POC documentation and identified that resident #005's bathing choice was documented as "not applicable " on one particular date in March and that there was no documentation for the resident's bathing choice on two additional dates in March 2019.

Inspector #681 reviewed the progress notes in resident #005's health care record for a specified period in March 2019, and was unable to identify any progress notes in the health care record related to bathing.

During an interview with the Staffing Coordinator, they identified that on one of the particular dates, the home was short two PSWs on a specified shift, and that on the two additional dates, the home was short four PSWs on a specified shift.

During an interview with PSW #137, they stated that they worked in the specified Home Area on a particular date in March 2019. PSW #137 stated that they were not assigned to complete resident #005's bathing choice, but that they recalled that resident #005's bathing choice was not completed. The Inspector then

spoke with PSW #139, who stated that they were assigned to provide resident #005 their bathing choice, but that they did not complete the bathing choice because it was supposed to be completed on another day of the week. PSW #137 stated that they documented the bathing choice as "not applicable". The Inspector verified that there was no documentation to indicate that the resident's bathing choice was completed on the other day of the week.

During an interview with PSW #114, they stated that they were assigned to complete resident #005's bathing choice on two specified dates in March 2019. PSW #114 stated that when the home was short staffed, they could not always complete the assigned resident's bathing choice. PSW #114 stated that they could not recall if resident #005's bathing choice was completed on the two specified dates, but PSW #114 stated that if they had completed the resident's bathing choice, they would have documented it in the POC.

C) During an interview with Inspector #681, resident #014 stated that they had missed their bathing choice on a particular date in March 2019, because the home was short staffed. Resident #014 stated that the missed bathing choice had not been completed on another shift.

Inspector #642 reviewed the "Assignment Sheet" for a specified Home Area, which indicated that resident #014 was to receive their bathing choice on two specified dates each week. The Inspector reviewed the POC documentation and identified that on the particular date, there was no documentation to indicate that resident #014 received their bathing choice.

Inspector #681 reviewed the progress notes in resident #014's health care record for a specified period of time in March 2019. The Inspector did not identify any progress notes related to bathing.

Inspector #642 reviewed the "Daily Home Area Record" for the specified Home Area and identified that there was nothing written on the document related to resident #014's bathing choice on the particular date.

During an interview with the Staffing Coordinator, they stated that, on the particular date, the home was short three PSWs on a specified shift.

During an interview with PSW #140, they stated that the specified Home Area was short staffed on the particular date. PSW #140 stated that when the Home Area was short staffed, they had to make decisions about which resident's bathing choice to complete, taking into consideration which residents had already received their bathing choice that week. PSW #140 stated that resident #014's bathing choice was not given on the particular date, because the home area was short staffed and the resident had already received their bathing choice that week.

During an interview with PSW #115, they stated that every time the home was short staffed, there were residents who did not receive their bathing choice. PSW #115 stated that residents who were not cognitive were more likely to have their bathing choice missed compared to residents who were cognitive or residents who had family members that were frequently present in the home.

D) Inspector #681 reviewed resident #013's health care record and identified a progress note that was created by RPN #130 on a particular date in March 2019. The progress note indicated that resident #013 was given a different bathing choice instead of their scheduled bathing choice.

The Inspector reviewed the "Assignment Sheet" from a specified Home Area, which identified that resident #013 was to receive their bathing choice on two specified dates each week.

The Inspector reviewed the POC for resident #013 and identified that resident #013's bathing choice was signed as completed on the particular date in March 2019.

During an interview with RPN #130, they stated that on the particular date, the specified Home Area was short staffed and that, for a portion of the shift, the Home Area only had two PSWs. RPN #130 stated that resident #013 was supposed to get their bathing choice on the particular date, but their bathing choice was not completed because the Home Area was short staffed and staff "just could not get [the resident's bathing choice] done". RPN #130 stated that, of the five residents who were supposed to receive their bathing choice on that day, only two residents received their bathing choice.

During interviews with PSW #131 and PSW #132, they stated that when a resident was given a specific type of bathing choice, it would be documented in the POC as completed, even if the resident was supposed to receive a different bathing choice. PSW #131 and PSW #132 stated that they were unable to get a resident's bathing choice done when the Home Area was short staffed.

During an interview with PSW #123, they also stated that residents were being given a specific type of bathing choice instead of their selected bathing choice because the home had been short staffed. PSW #123 stated that staff were documenting the resident's bathing choice as completed when the resident was provided with a bathing choice contrary to their wishes.

The Inspector interviewed Co-DOC #102 and Co-DOC #103, who stated that the provision of personal care, such as the resident's bathing choice, must be documented in order to know that the bathing choice was completed. Co-DOC #102 and Co-DOC #103 stated that if staff were unable to complete the resident's bathing choice then a "Bath Audit Form" was supposed to be filled out.

The severity of this issue was determined to be a level two, as there was minimal harm or the potential for actual harm to the residents of the home. The scope of the issue was a level three, as it was identified to be a widespread issue among the residents who were reviewed. The home had a level three compliance history, as they had related non-compliance with this section of the LTCHA that included:

- a CO issued January 29, 2019, (#2019_679638_0002). (642)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 21, 2019

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 8th day of April, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Stephanie Doni

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