Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 23, 2020	2020_841679_0015 (A1)	015513-20, 021494-20, 021884-20, 022055-20	Complaint

Licensee/Titulaire de permis

Valley East Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street Midland ON L4R 2E1

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

Amended by MICHELLE BERARDI (679) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has been granted an extension to four compliance orders to allow the home to achieve sustainable compliance.

Issued on this 23rd day of December, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by MICHELLE BERARDI (679) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 2-6 and 9, 2020. Additional off-site activities were conducted on November 13, 2020.

The following intakes were inspected upon during this Complaint Inspection:

- Three intakes related to staffing shortages; and,

- One intake related to bed rail concerns.

A Critical Incident System (CIS) Inspection #2020_841679_0014, was conducted concurrently with this inspection.

A Compliance Order related to LTCHA, 2007, s.6 (7), identified in concurrent inspection #2020_841679_0014, was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-DOCs, Restorative Care Coordinator, Physiotherapists, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff, Maintenance Aide, screeners, resident's and their families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Dining Observation
Infection Prevention and Control
Safe and Secure Home
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **7 WN(s)**
- **3 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used for four residents, the residents were assessed and their bed systems were evaluated in accordance with prevailing practices to minimize the risk to the resident.

In March 2019, the Director notified the Long-term Care Home Administrators, via a memo, regarding the proper use of bed rails. The documents referenced in the memo were prevailing practices and provided necessary guidance in establishing a clinical assessment where bed rails were used.

Inspector #744 reviewed the licensee's "Bed Safety Assessment for use of Bedrail (s)" form for a resident, and it was determined that it was not fully developed in accordance with the memo's document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". The assessment guideline offered examples of key assessment questions that guided decision-making for the use of bed rails. Inspector #744 identified key assessment questions not found in the "Bed Safety Assessment for use of Bedrail(s)" form, which included: Resident medical diagnosis, to demonstrate the ability to safely use the bed rails, continence patterns, medication use, pain management issues, interdisciplinary assessors' names and bed/mattress type.

The guidance document also emphasized the need for the interdisciplinary team to be involved in the resident assessment for bed rails. Inspector #744 determined that the nursing assessment section of the "Bed Safety Assessment for Use of

Bedrails" was not completed. The Restorative Care Coordinator/Physiotherapy Assistant (PTA) stated that they completed the nursing assessment themselves and did not consult nursing staff for this assessment.

The home's policy stated that residents that qualified for a bed rail would be assessed quarterly using the Point Click Care (PCC) Bed Safety Assessment in collaboration with the interdisciplinary team. Inspector #744 performed a record review on three residents, which found that a bed safety assessment was not completed for these residents.

A request was made for the home's bed rail assessments, however, the home was not able to produce all the required bed rail assessments.

Sources: "Resident rights, care and services- Safe and Secure Home- Bedrails and Bed System Safety" Policy (revised 2018-03-01); Clinical Guidance for the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings, April 2003; Four residents' electronic assessments; interview with the Restorative Care Coordinator/PTA and other staff. [s. 15. (1) (a)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out the planned care for two residents, with respect to receiving additional staff assistance.

Three complaints were submitted to the Director related to staffing shortages. During an interview with a complainant, they indicated that residents in the home required additional staff assistance; however, the additional staff assistance was not being provided.

a) The care plan for a resident indicated the use of additional staff assistance, to be implemented at specified times. The Co-Director of Care (DOC) indicated that the resident required additional staff assistance at specific times; however, the care plan did not identify information related to the use of the additional staff assistance at all the required times.

b) A resident's care plan and kardex did not identify a focus or interventions related to the resident’s need for additional staff assistance. A PSW indicated that the resident required the additional staff assistance; however, staff did not know when they were going to implement the additional staff assistance, as the resources weren't always available. The Co-DOC indicated that the resident required additional staff assistance, and that staff would be made aware of this

through the resident's care plan; however, the care plan did not identify information related to the need for the additional staff assistance.

Sources: Three Complaint intakes; Resident's electronic records including progress notes and care plan; staff interviews with a PSW, Co- DOCs, and other staff members; Inspector's observations; Policy titled "Resident Rights, Care and Services- Plan of Care" (dated September 24, 2019). [s. 6. (1) (a)]

2. The licensee has failed to ensure that a resident had their call bell within reach.

A resident was at risk for falls and was required to have their call bell within reach. There were multiple observations of the call bell not within reach as outlined in the resident's care plan.

Sources: A residents plan of care; Inspector #744 observations; interviews with PSWs, and other staff. [744] [s. 6. (7)]

3. The licensee has failed to ensure that a resident received the physical assistance of staff for transfers.

A resident's care plan and a physiotherapy assessment, both indicated that the resident was to receive the physical assistance of one staff member for transfers. The Inspector observed that the resident transferred themselves independently while in common areas of the home. During separate interviews with three PSWs and two Registered Nurses (RNs), they each identified that the resident was able to transfer themselves independently and did not require the assistance of staff for transfers.

The resident was at minimal risk of harm when they did not receive the assistance with transferring that was required. Both the Physiotherapist and Restorative Care Coordinator provided the Inspector with examples of how the resident had sustained prior falls.

Sources: A resident's care plan; Physiotherapy Assessment; Inspector #681's observations; and interviews with the Physiotherapist, Restorative Care Coordinator, and other staff. [681] [s. 6. (7)]

4. The licensee has failed to ensure that a resident received additional staff

assistance.

A resident's care plan indicated that they required additional staff assistance. Inspector #681 observed the resident without additional staff assistance. In addition, a review of the electronic progress notes identified that the additional staff assistance was not provided on two occasions.

Sources: Three Complaint intakes; Inspector #681's observation; Interviews with a PSW, Co-DOC , the DOC, and other staff; care plan and progress notes for a resident; and, Policy titled “Resident Rights, Care and Services- Plan of Care” (dated September 24, 2019). [s. 6. (7)]

5. The licensee has failed to ensure that the provision of toileting care for three residents was documented.

In an interview with a complainant, they indicated that residents were being found in saturated briefs, due to staffing shortages in the home. During interviews with seven staff members, they all informed the Inspector of staffing shortages in the home, with five staff members identifying information regarding resident’s being found in soiled briefs. A PSW also indicated that night shift worked short, and that some resident's weren't receiving care.

Inspector #679 reviewed the electronic records for three residents, and identified missing documentation related to toileting. Specifically, the Inspector identified two shifts with missing documentation for one resident; three shifts with missing documentation for the second resident, and six shifts with missing documentation for the third resident. The Co-DOC confirmed that it was the expectation that staff document on a resident’s continence care in Point of Care (POC).

Sources: Three Complaint intakes; staff interviews with PSWs, RPNs, a RN and other staff; “Resident Rights, Care and Services- Required Programs- Continence Care and Bowel Management Program” policy (Dated 2018-02-28) and electronic resident records including: POC documentation, progress notes and kardex; Documentation Survey Report for three residents. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

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 ensuring that there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents, with respect to the utilization of personal protective equipment (PPE) required by the direction of the Chief Medical Officer of Health in Directive #3 for Long-Term Care Homes.

Directive #3, effective on October 16, 2020, indicated that all new admissions and readmissions to the home must complete 14-days of self-isolation, under isolation precautions. Inspector #681 observed that two residents had signage outside of their rooms indicating that they were on isolation.

a) The Inspector observed a PSW in a resident's room, wearing a procedural mask and a pair of gloves. No other PPE was utilized by this staff member at this time. The Inspector observed that the PSW exited the resident's room still wearing the same pair of gloves and walked down the hall. The Inspector did not observe

the PSW remove their gloves or perform hand hygiene after exiting the resident's room.

b) The Inspector observed a PSW enter a resident's room to provide the resident with a beverage from the nourishment cart. The PSW was only wearing a procedural mask when they entered the resident's room. No other PPE was utilized by this staff member at this time.

c) The Inspector subsequently observed a PSW enter another resident's room to provide the resident with a beverage from the nourishment cart. The PSW was only wearing a procedural mask when they entered this resident's room.

Staff should have utilized full PPE, which included a gown, gloves, mask, and eye protection when entering the rooms of two residents. The PSW should have also removed their gloves and performed hand hygiene when they exited a resident's room. The improper use of PPE and hand hygiene placed other residents in the home at risk of disease transmission.

Sources: Inspector observations; COVID-19 Directive #3 for Long-Term Care Homes effective October 16, 2020; two residents' electronic records; and interviews with the DOC and other staff.

2. The licensee has failed to ensure that the home was a safe and secure environment for its residents, with respect to the use of surgical/procedure mask by visitors.

Directive #3, effective on October 16, 2020, indicated that for all indoor visits, visitors must wear a surgical/procedure mask at all times.

a) Inspector #681 observed two visitors in the home who were wearing cloth masks instead of surgical/procedure masks. The visitors stated to the Inspector that they were never asked by the home to wear a surgical/procedure mask instead of a cloth mask.

b) The Inspector observed a visitor in a resident's room. The visitor was wearing a cloth mask instead of surgical/procedure mask. The visitor stated to the Inspector that they were not asked to switch from a cloth mask to a surgical mask when they entered the home.

c) The Inspector observed two visitors in a resident's room, wearing alternatives to a surgical/procedure mask. The Inspector spoke with the visitors who stated that they were not asked to wear a surgical/procedure mask when they entered the home and that they would have put on a surgical/procedure mask had they been asked.

Visitors should have only been permitted to enter the home after they had donned a surgical/procedure mask. Visitors wearing face coverings that were not surgical/procedure masks placed residents in the home at risk of disease transmission.

Sources: Inspector observations; COVID-19 Directive #3 for Long-Term Care Homes effective October 16, 2020; Ministry of Long-Term Care COVID-19 Visiting Policy effective October 7, 2020; interviews with visitors; and interviews with the DOC and other staff.

3. The licensee has failed to ensure that the home was a safe and secure environment for its residents, with respect to the use of surgical/procedure masks by staff.

Directive #3, effective on October 16, 2020, indicated that long-term care homes should immediately implement that all staff wear surgical/procedure masks at all times for source control for the duration of their full shifts. Inspector #679 observed a PSW pull down their mask while feeding a resident in the dining room. [679]

Sources: Inspector observations; COVID-19 Directive #3 for Long-Term Care Homes effective October 16, 2020.

4. The licensee has failed to ensure that the home was a safe and secure environment for its residents, with respect to the staffing levels in the home.

Three complaints were submitted to the Director related to staffing shortages.

a) A complainant indicated that the home was short staffed on night shifts, leaving staff to cover multiple units. Inspector #679 conducted an observation of a Home Area (HA) at 0542 hours, and could not locate a staff member on the home area. At 0546 hours, the RN entered the home area; however, they were then called away from the unit. In an interview with the RN, they identified the home was

short a PSW on the HA from 0230 hours to 0630 hours on the date of the observation. The RN identified when the Inspector entered the home, they were working on a different HA.

b) Two PSWs identified that there had been occasions where residents had been transferred with a mechanical lift independently. The home's policy indicated that staff were not to lift or transfer any dependent (non- weight bearing) resident on their own. Two staff members trained in the safe operation of this mechanical lift must be with the residents while the lifts controls were being used and/or the lift was being maneuvered. In an interview with the Co-DOC, they indicated that two staff were required to transfer residents at all times.

c) Three PSWs indicated to the Inspector that there were staffing shortages in the home, and that when the home had worked short staffed, they had performed care on residents who required two-person assistance for care independently. A PSW indicated that their HA was working short on the day of the interview, and that they had completed care on resident's who required two-person assistance independently. A resident list provided by the DOC indicated that there were multiple residents on each home area who required two-person assistance.

d) Inspector #679 reviewed the PSW staffing shortages for a specified month and identified the following shift shortages: 30 day shifts, 28 afternoon shifts and 7 night shifts, noting eight dates in which the home was short greater than one PSW on a shift. The Inspector reviewed the PSW staffing shortages for an additional four day period, and identified the following shift shortages: 8 day shifts, and 2 evening shifts, noting three dates in which the home was short greater than one PSW on a shift.

e) In interviews with staff members, residents and family members they indicated that there were staffing shortages in the home. The following information was provided to the Inspectors as examples of how care was affected related to short staffing:
- Three residents, two family members and 10 staff indicated residents did not always receive their scheduled baths/showers. See WN #4 for further details;
- Two PSWs identified concerns related to meal service; specifically that residents had to wait to be fed. See WN #7 for further details;
- A PSW indicated that when the home worked short staffed, "sometimes people forget alarms". See WN #2-2 for further details;
- A complainant indicated that residents in the home required additional staff

assistance, and that the resources weren't available. See WN #2-1 and 4, for further details; and,
- A PSW and a RN identified that documentation may not get completed. See WN #2-5, for further details.

Sources: Three Complaint intakes; Staff, resident and family interviews; observations; resident list; Resident Transfer, Lift and Positioning Guidelines policy last revised (February 14, 2019) and Resident Rights, Care and Services-Plan of Care policy (dated September 24, 2019). [s. 5.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #4: 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 :

The licensee has failed to ensure that residents of the home were bathed, at a minimum, twice a week by the method of his or her choice.

Three complaints were submitted to the Director related to staffing shortages in the home, and how this resulted in resident's not being provided their scheduled bath/shower. During an interview with three residents, two family members and 10 staff, they indicated when the home worked short staffed, residents did not always receive their scheduled baths/showers.

a) Two PSWs indicated that a resident had not received their bath/shower in two weeks. The "Documentation Survey Report" indicated "No" or "Not Applicable" on two dates. The Co-DOC indicated on one date, staff had documented in a progress note that the resident's bath was not given due to time constraints; on a second date, the day binder indicated no residents received their bath.

b) Two PSWs indicated that a resident had not received their scheduled bath/shower in three weeks. The "Documentation Survey Report" for the resident identified missing documentation on four dates, related to the resident's bathing task; Documentation on two dates, indicated "Not Applicable". The Co-DOC indicated that there was no documentation in the electronic progress notes regarding the bathing, that the documentation in the day binder was blank on four occasions, and on one date, the documentation indicated "No".

c) A complainant indicated that a resident had not received their scheduled bath/shower for ten days. The "Documentation Survey Report" for the resident identified their bath had been documented as "No" on six dates.

d) A PSW indicated that a resident had not received their scheduled bath/shower for two weeks. The "Documentation Survey Report" identified missing documentation on four dates, and "No" was documented on another date. In two progress notes, staff had documented that the bath was unable to be given due to staffing and time constraints.

e) The "Bath Audit Forms" for three dates identified that 10 residents had not received their scheduled bath/shower due to staffing shortages; One resident had received their scheduled bath/shower the next date. In addition, Inspector #679 reviewed the "Follow Up Question Report" and identified nine additional residents who had their baths/showers documented as "Not Applicable" on one or more occasions over a one-month period.

Sources: Three Complaint intakes; Resident Rights, Care and Services- Nursing

and Personal Services- Bathing policy (Dated September 16, 2013); Follow Up Question Report; Documentation Survey Reports; Unit Assignment Sheets; Day Book; Resident records including: progress notes, kardex and POC charting; Interviews with residents, family members, PSWs, Co-DOCs, and other staff. [s. 33. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 004

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the policy to promote zero tolerance of resident abuse and neglect was complied with.

A PSW indicated that a resident was found having not been provided assistance with their care needs, and that the concern had been brought forward to the registered staff on the unit. An RPN identified they were aware of the incident involving the resident, and that this concern was brought forth to the charge nurse.

The home's policy indicated that any person who had reasonable grounds to suspect neglect of a resident was to immediately report the suspicion to the most senior administrative personnel or charge nurse, and that the manager on call was to be notified; The policy further indicated allegations of neglect were to be reported to the Ministry of Long-Term Care.

The DOC provided the Inspector with two Critical Incident (CI) report numbers related to allegations of neglect; however, neither related to the resident.

Sources: Three Complaint intakes; Staff Interviews; Ministry of Long-Term Care online reporting portal; Policy titled “Resident Rights, Care and Services- Abuse- Zero- Tolerance Policy for Resident Abuse and Neglect” (dated 2020-06-30). [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the policy to promote zero tolerance of resident abuse and neglect was complied with, to be implemented voluntarily.

WN #6: 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 has failed to ensure that all staff participated in the implementation of the infection prevention and control program, specifically with regards to hand hygiene and the refilling of hand sanitizer dispensers throughout the home.

During an observation of a meal service, the Inspector identified four occasions in which PSWs had failed to perform hand hygiene after contact with a resident or prior to initiating a new task.

Sources: Inspector Observations; Staff Interviews with a PSW, RN and other staff; "Operation of Homes – Infection Control – Hand Hygiene Program", last revised June 26, 2020 [s. 229. (4)]

2. a) Inspector #681 observed that two PSWs failed to use proper hand washing techniques on multiple occasions during a dining observation. Specifically either with lathering, scrubbing and/or drying their hands.

b) During the inspection, Inspector #681 observed that seven resident rooms did not have a bottle of hand sanitizer in the holder located at the entrance of the room. The Inspector also noted that the resident residing in one of the rooms was on isolation at the time of the inspection. Repeat observations conducted during the inspection identified that these rooms were still missing bottles of hand sanitizer. Three PSWs all indicated to the Inspector that the bottles of hand sanitizer in resident rooms were either often empty or there was no bottle in the holder.

As per the home's Hand Hygiene Program, staff were to perform hand hygiene before and after contact with a resident or the resident's environment. Staff were also to ensure that, when washing their hands with soap and water, they rubbed

their hands together creating a soapy lather for 15 seconds; rinsed their hands well under running water; dried their hands with paper towel; and used paper towel to turn off the taps in order to not re-contaminate their hands. The home's program also identified that the home's Environmental Services Manager was to ensure that there was a process for refilling all soap and hand sanitizer dispensers.

Sources: Inspector observations; the home's policy titled "Operation of Homes – Infection Control – Hand Hygiene Program", last revised June 26, 2020; and interviews with the DOC and other staff. [s. 229. (4)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident, who required assistance with eating or drinking was not served a meal until someone was available to provide the assistance required.

During a meal observation, Inspector #679 observed a PSW walk by a resident, assist them with a spoonful of food then proceed to continue with the meal service. The PSW then indicated that the resident would be eating if they were fed; the resident was later provided with assistance. The resident's kardex indicated that they were dependent on staff for meal assistance.

Sources: Three Complaint intakes; Inspector observations; Interview with a PSW, Co-DOC and other staff; a resident's care plan; "Resident Rights, Care and Services- Plan of Care" (dated September 24, 2019) policy. [s. 73. (2) (b)]

Issued on this 23rd day of December, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MICHELLE BERARDI (679) - (A1)
Inspection No. / No de l'inspection :	2020_841679_0015 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	015513-20, 021494-20, 021884-20, 022055-20 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 23, 2020(A1)
Licensee / Titulaire de permis :	Valley East Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, Midland, ON, L4R-2E1
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 :	Stephanie Zakrocki

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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 Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee must be compliant with s. 15. (1) of the Long-Term Care Home's Act (LTCHA), 2007.

Specifically the licensee shall:
a) Amend the home's existing electronic "Bed Safety Assessment for use of Bedrail(s)" form so that it includes all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S.F.D.A, April 2003) recommended as prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards".

b) Ensure the interdisciplinary team reassesses all residents that have bed rails, by utilizing the amended bed safety assessment form.

c) Ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and other safety issues related to the use of bed rails are addressed, including height and latch reliability.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used for four residents, the residents were assessed and their bed systems were evaluated in accordance with prevailing practices to minimize the risk to the resident.

In March 2019, the Director notified the Long-term Care Home Administrators, via a memo, regarding the proper use of bed rails. The documents referenced in the memo were prevailing practices and provided necessary guidance in establishing a clinical assessment where bed rails were used.

Inspector #744 reviewed the licensee's "Bed Safety Assessment for use of Bedrail (s)" form for a resident, and it was determined that it was not fully developed in accordance with the memo's document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". The assessment guideline offered examples of key assessment questions that guided decision-making for the use of bed rails. Inspector

#744 identified key assessment questions not found in the "Bed Safety Assessment for use of Bedrail(s)" form, which included: Resident medical diagnosis, to demonstrate the ability to safely use the bed rails, continence patterns, medication use, pain management issues, interdisciplinary assessors' names and bed/mattress type.

The guidance document also emphasized the need for the interdisciplinary team to be involved in the resident assessment for bed rails. Inspector #744 determined that the nursing assessment section of the "Bed Safety Assessment for Use of Bedrails" was not completed. The Restorative Care Coordinator/Physiotherapy Assistant (PTA) stated that they completed the nursing assessment themselves and did not consult nursing staff for this assessment.

The home's policy stated that residents that qualified for a bed rail would be assessed quarterly using the Point Click Care (PCC) Bed Safety Assessment in collaboration with the interdisciplinary team. Inspector #744 performed a record review on three residents, which found that a bed safety assessment was not completed for these residents.

A request was made for the home's bed rail assessments, however, the home was not able to produce all the required bed rail assessments.

Sources: "Resident rights, care and services- Safe and Secure Home- Bedrails and Bed System Safety" Policy (revised 2018-03-01); Clinical Guidance for the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings, April 2003; Four residents' electronic assessments; interview with the Restorative Care Coordinator/PTA and other staff. [s. 15. (1) (a)]

An order was made by taking the following factors into account:

Severity: Actual risk was identified as the home was unable to provide documentation to indicate that the bed systems were assessed for any of the residents in the home who utilized bed rails.

Scope: The scope of this non-compliance was widespread, as the home was unable to provide documentation to indicate that the bed systems were assessed for any of

the residents in the home who utilized bed rails. Additionally, three residents reviewed who utilized bed rails had no resident assessments related to the use of the bed rails.

Compliance History: Nine previous Compliance Orders (COs) all of which have been complied, 17 Voluntary Plans of Correction (VPCs) and nine Written Notifications (WNs) were issued to the home related to different sub-sections of the legislation in the past 36 months.
(744)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 22, 2021(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the LTCHA, 2007.

Specifically, the licensee must:
a) Ensure a resident's call bell is within reach while in their chair, as outlined in their plan of care;
b) Ensure a resident receives assistance with transferring, as identified in the resident's plan of care; and,
c) Ensure that additional staff assistance is provided to a resident, as specified in the resident's plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident had their call bell within reach.

A resident was at risk for falls and was required to have their call bell within reach. There were multiple observations of the call bell not within reach as outlined in the resident's care plan.

Sources: A residents plan of care; Inspector #744 observations; interviews with PSWs, and other staff. [744] [s. 6. (7)]
(679)

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

2. The licensee has failed to ensure that a resident received the physical assistance of staff for transfers.

A resident's care plan and a physiotherapy assessment, both indicated that the resident was to receive the physical assistance of one staff member for transfers. The Inspector observed that the resident transferred themselves independently while in common areas of the home. During separate interviews with three PSWs and two Registered Nurses (RNs), they each identified that the resident was able to transfer themselves independently and did not require the assistance of staff for transfers.

The resident was at minimal risk of harm when they did not receive the assistance with transferring that was required. Both the Physiotherapist and Restorative Care Coordinator provided the Inspector with examples of how the resident had sustained prior falls.

Sources: A resident's care plan; Physiotherapy Assessment; Inspector #681’s observations; and interviews with the Physiotherapist, Restorative Care Coordinator, and other staff. [681] [s. 6. (7)] (679)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

3. The licensee has failed to ensure that a resident received additional staff assistance.

A resident's care plan indicated that they required additional staff assistance. Inspector #681 observed the resident without additional staff assistance. In addition, a review of the electronic progress notes identified that the additional staff assistance was not provided on two occasions.

Sources: Three Complaint intakes; Inspector #681's observation; Interviews with a PSW, Co-DOC , the DOC, and other staff; care plan and progress notes for a resident; and, Policy titled "Resident Rights, Care and Services- Plan of Care" (dated September 24, 2019). [s. 6. (7)]

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm identified for the three residents, as two residents who experienced a number of falls were observed without a fall prevention intervention and one resident was observed without having the required additional staff assistance.

Scope: The scope of this non-compliance was a pattern as it related to two out of three residents at risk for falls reviewed, and one out of two residents reviewed who required additional staff assistance.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 6. (7), and one CO, two VPCs and one WN were issued to the home. (679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 22, 2021(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5. the LTCHA, 2007.

Specifically the licensee shall:
a) Conduct weekly audits of resident home areas to ensure that staff and visitors are using Personal Protective Equipment (PPE) as required by the Chief Medical Officer of Health in Directive #3 for Long-Term Care Homes. This process shall be documented to include: the name of the individual conducting the audit, the date of the audit, the result of the audit and any actions taken to rectify concerns identified in the audit. Conduct and document the audit's until no further concerns are identified in the audits for a two-week period.

b) Ensure that no resident home area is left unattended by staff;

c) Ensure that care is provided to residents who require two person assistance for care as specified in their care plan; and,

d) Ensure that the home's policy "Resident Transfer, Lift and Positioning Guidelines" is complied with; specifically ensuring that two staff are present when using mechanical lifts to transfer residents.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents, with respect to the utilization of personal protective equipment (PPE) required by the direction of the Chief Medical Officer of Health in

Directive #3 for Long-Term Care Homes.

Directive #3, effective on October 16, 2020, indicated that all new admissions and readmissions to the home must complete 14-days of self-isolation, under isolation precautions. Inspector #681 observed that two residents had signage outside of their rooms indicating that they were on isolation.

a) The Inspector observed a PSW in a resident's room, wearing a procedural mask and a pair of gloves. No other PPE was utilized by this staff member at this time. The Inspector observed that the PSW exited the resident's room still wearing the same pair of gloves and walked down the hall. The Inspector did not observe the PSW remove their gloves or perform hand hygiene after exiting the resident's room.

b) The Inspector observed a PSW enter a resident's room to provide the resident with a beverage from the nourishment cart. The PSW was only wearing a procedural mask when they entered the resident's room. No other PPE was utilized by this staff member at this time.

c) The Inspector subsequently observed a PSW enter another resident's room to provide the resident with a beverage from the nourishment cart. The PSW was only wearing a procedural mask when they entered this resident's room.

Staff should have utilized full PPE, which included a gown, gloves, mask, and eye protection when entering the rooms of two residents. The PSW should have also removed their gloves and performed hand hygiene when they exited a resident's room. The improper use of PPE and hand hygiene placed other residents in the home at risk of disease transmission.

Sources: Inspector observations; COVID-19 Directive #3 for Long-Term Care Homes effective October 16, 2020; two residents' electronic records; and interviews with the DOC and other staff.

2. The licensee has failed to ensure that the home was a safe and secure environment for its residents, with respect to the use of surgical/procedure mask by visitors.

Directive #3, effective on October 16, 2020, indicated that for all indoor visits, visitors

must wear a surgical/procedure mask at all times.

a) Inspector #681 observed two visitors in the home who were wearing cloth masks instead of surgical/procedure masks. The visitors stated to the Inspector that they were never asked by the home to wear a surgical/procedure mask instead of a cloth mask.

b) The Inspector observed a visitor in a resident's room. The visitor was wearing a cloth mask instead of surgical/procedure mask. The visitor stated to the Inspector that they were not asked to switch from a cloth mask to a surgical mask when they entered the home.

c) The Inspector observed two visitors in a resident's room, wearing alternatives to a surgical/procedure mask. The Inspector spoke with the visitors who stated that they were not asked to wear a surgical/procedure mask when they entered the home and that they would have put on a surgical/procedure mask had they been asked.

Visitors should have only been permitted to enter the home after they had donned a surgical/procedure mask. Visitors wearing face coverings that were not surgical/procedure masks placed residents in the home at risk of disease transmission.

Sources: Inspector observations; COVID-19 Directive #3 for Long-Term Care Homes effective October 16, 2020; Ministry of Long-Term Care COVID-19 Visiting Policy effective October 7, 2020; interviews with visitors; and interviews with the DOC and other staff.

3. The licensee has failed to ensure that the home was a safe and secure environment for its residents, with respect to the use of surgical/procedure masks by staff.

Directive #3, effective on October 16, 2020, indicated that long-term care homes should immediately implement that all staff wear surgical/procedure masks at all times for source control for the duration of their full shifts. Inspector #679 observed a PSW pull down their mask while feeding a resident in the dining room. [679]

Sources: Inspector observations; COVID-19 Directive #3 for Long-Term Care Homes

effective October 16, 2020.

4. The licensee has failed to ensure that the home was a safe and secure environment for its residents, with respect to the staffing levels in the home.

Three complaints were submitted to the Director related to staffing shortages.

a) A complainant indicated that the home was short staffed on night shifts, leaving staff to cover multiple units. Inspector #679 conducted an observation of a Home Area (HA) at 0542 hours, and could not locate a staff member on the home area. At 0546 hours, the RN entered the home area; however, they were then called away from the unit. In an interview with the RN, they identified the home was short a PSW on the HA from 0230 hours to 0630 hours on the date of the observation. The RN identified when the Inspector entered the home, they were working on a different HA.

b) Two PSWs identified that there had been occasions where residents had been transferred with a mechanical lift independently. The home's policy indicated that staff were not to lift or transfer any dependent (non- weight bearing) resident on their own. Two staff members trained in the safe operation of this mechanical lift must be with the residents while the lifts controls were being used and/or the lift was being maneuvered. In an interview with the Co-DOC, they indicated that two staff were required to transfer residents at all times.

c) Three PSWs indicated to the Inspector that there were staffing shortages in the home, and that when the home had worked short staffed, they had performed care on residents who required two-person assistance for care independently. A PSW indicated that their HA was working short on the day of the interview, and that they had completed care on resident's who required two-person assistance independently. A resident list provided by the DOC indicated that there were multiple residents on each home area who required two-person assistance.

d) Inspector #679 reviewed the PSW staffing shortages for a specified month and identified the following shift shortages: 30 day shifts, 28 afternoon shifts and 7 night shifts, noting eight dates in which the home was short greater than one PSW on a shift. The Inspector reviewed the PSW staffing shortages for an additional four day period, and identified the following shift shortages: 8 day shifts, and 2 evening shifts,

noting three dates in which the home was short greater than one PSW on a shift.

e) In interviews with staff members, residents and family members they indicated that there were staffing shortages in the home. The following information was provided to the Inspectors as examples of how care was affected related to short staffing:
- Three residents, two family members and 10 staff indicated residents did not always receive their scheduled baths/showers. See WN #4 for further details;
- Two PSWs identified concerns related to meal service; specifically that residents had to wait to be fed. See WN #7 for further details;
- A PSW indicated that when the home worked short staffed, "sometimes people forget alarms". See WN #2-2 for further details;
- A complainant indicated that residents in the home required additional staff assistance, and that the resources weren't available. See WN #2-1 and 4, for further details; and,
- A PSW and a RN identified that documentation may not get completed. See WN #2 -5, for further details.

Sources: Three Complaint intakes; Staff, resident and family interviews; observations; resident list; Resident Transfer, Lift and Positioning Guidelines policy last revised (February 14, 2019) and Resident Rights, Care and Services- Plan of Care policy (dated September 24, 2019). [s. 5.]

An order was made by taking the following factors into account:

Severity: Actual risk was identified in the home related staffing levels affecting resident care, as well as the PPE usage by staff and visitors.

Scope: The scope of this non-compliance was a pattern because of the number of identified concerns related to ensuring a safe environment for its residents.

Compliance History: Nine previous Compliance Orders (COs) all of which have been complied, 17 Voluntary Plans of Correction (VPCs) and nine Written Notifications (WNs) were issued to the home related to different sub-sections of the legislation in the past 36 months. (679)

Jan 22, 2021(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with s. 33 (1) of Ontario Regulation 79/10.

Specifically the licensee shall:
a) Conduct weekly audits to ensure that every 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; and,

b) Maintain documentation of the audit, which should include: the name of the individual conducting the audit, the date of the audit, the date of any missed showers/baths and the date the next shower/bath was received. Conduct and document the audit's until it has been determined that the residents of the home have been bathed, at minimum twice a week by the method of his or her choice, or more frequently as determined by the resident's hygiene requirements, for a two week period.

Grounds / Motifs :

1. The licensee has failed to ensure that residents of the home were bathed, at a minimum, twice a week by the method of his or her choice.

Three complaints were submitted to the Director related to staffing shortages in the home, and how this resulted in resident's not being provided their scheduled bath/shower. During an interview with three residents, two family members and 10

staff, they indicated when the home worked short staffed, residents did not always receive their scheduled baths/showers.

a) Two PSWs indicated that a resident had not received their bath/shower in two weeks. The "Documentation Survey Report" indicated "No" or "Not Applicable" on two dates. The Co-DOC indicated on one date, staff had documented in a progress note that the resident's bath was not given due to time constraints; on a second date, the day binder indicated no residents received their bath.

b) Two PSWs indicated that a resident had not received their scheduled bath/shower in three weeks. The "Documentation Survey Report" for the resident identified missing documentation on four dates, related to the resident's bathing task; Documentation on two dates, indicated "Not Applicable". The Co-DOC indicated that there was no documentation in the electronic progress notes regarding the bathing, that the documentation in the day binder was blank on four occasions, and on one date, the documentation indicated "No".

c) A complainant indicated that a resident had not received their scheduled bath/shower for ten days. The "Documentation Survey Report" for the resident identified their bath had been documented as "No" on six dates.

d) A PSW indicated that a resident had not received their scheduled bath/shower for two weeks. The "Documentation Survey Report" identified missing documentation on four dates, and "No" was documented on another date. In two progress notes, staff had documented that the bath was unable to be given due to staffing and time constraints.

e) The "Bath Audit Forms" for three dates identified that 10 residents had not received their scheduled bath/shower due to staffing shortages; One resident had received their scheduled bath/shower the next date. In addition, Inspector #679 reviewed the "Follow Up Question Report" and identified nine additional residents who had their baths/showers documented as "Not Applicable" on one or more occasions over a one-month period.

Sources: Three Complaint intakes; Resident Rights, Care and Services- Nursing and Personal Services- Bathing policy (Dated September 16, 2013); Follow Up Question Report; Documentation Survey Reports; Unit Assignment Sheets; Day Book;

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Resident records including: progress notes, kardex and POC charting; Interviews with residents, family members, PSWs, Co-DOCs, and other staff. [s. 33. (1)]

An order was made by taking the following factors into account:

Severity: There was minimal risk identified, specifically related to the residents identified as they were required to receive their bath/shower twice per week.

Scope: The scope of this non-compliance was widespread as it affected four out of five residents identified in staff interviews and nine out of 10 reviewed from bath audit documentations.

Compliance History: Nine previous Compliance Orders (COs) all of which have been complied, 17 Voluntary Plans of Correction (VPCs) and nine Written Notifications (WNs) were issued to the home related to different sub-sections of the legislation in the past 36 months. (679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 22, 2021(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
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 23rd day of December, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by MICHELLE BERARDI (679) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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