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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 27, 2019	2018_695156_0006 (A1) v2	016725-18	Resident Quality Inspection

Licensee/Titulaire de permis

Park Lane Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

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

Park Lane Terrace
295 Grand River Street North PARIS ON N3L 2N9

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

Amended by MELODY GRAY (123) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance due date for CO #004 was changed to May 1, 2019.
The compliance due date for CO #005 was changed to May 15, 2019
The compliance due date for CO #006 was changed to May 15, 2019
The compliance due date for CO #008 was changed to May 15, 2019.

Issued on this 11st day of April, 2019 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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Amended by MELODY GRAY (123) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 12, 13, 16, 17, 18, 19, 24, 26, 27, 30, 31, August 1, 2, 3, 7, 8, 9, 10, 13, 14, 15, 16, 20, 21, 22, 23, 24, September 5, 6, 7, 11, 12, 13, 14, 2018

During this inspection the inspections listed below were conducted concurrently:

Complaints:

006339-18 related to abuse and neglect

012432-18 related to nutritional care

014132-18 related to care planning

016094-18 related to staffing

018007-18 related to staffing, nutritional care and dressing/grooming

018113-18 related to staffing and continence care

018378-18 related to staffing and abuse

018920-18 related to staffing, continence and skin and wound

018926-18 related to infection prevention and control

020277-18 related to nutritional care, menu planning, weights and bathing

023091-18 related to falls and skin and wound

012534-18 related to staffing, skin and wound

Critical Incidents:

028494-17 related to missing medication

021539-18 related to missing medication

021534-18 related to missing medication

001357-18 related to falls

002538-18 related to infection prevention and control

009768-18 related to abuse

017534-18 related to abuse

018579-18 related to abuse

020603-18 related to neglect

021738-18 related to abuse

022874-18 related to abuse

Follow-up:

003635-18 related to 24/7 RN

003636-18 related to resident charges

003634-18 related to skin and wound care

Inquiries:

0020984-18 related to staffing

022172-18 related to abuse

027030-17 related to falls prevention

009448-18 related to falls prevention

010157-18 related to falls prevention

017029-18 related to reporting and complaints

During the course of the inspection, the inspector(s) spoke with Administrator, acting Administrator, former Administrator, Director of Care (DOC), former DOC, registered nursing staff, former registered nursing staff, agency staff, Registered Dietitian (RD), former RD, Personal Support Worker (PSW) staff, Dietary Aides, Director of Culinary Services, Cook, Housekeeping and Laundry staff, Director of Environmental Services (DES), Vice President of Environmental Resources (VPER), Activity staff, Employee Services Coordinator, Director of Program and Support Services, Director of Business Services, consultant Pharmacist, Clinical Pharmacist, Social Worker, Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Coordinator, Behavioural Supports Ontario (BSO) staff, Corporate staff, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, observed medication passes and dining observations, reviewed clinical records, policies and procedures, the licensee's complaints log, investigation notes and conducted interviews.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

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

40 WN(s)
28 VPC(s)
8 CO(s)
1 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 LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations.

A complainant was interviewed and reported to the Inspector that the staff who provided care to the resident did not receive any orientation prior to working on the home area.

The home's Daily Assignment Sheets; the Orientation and Annual Education Binder - Agency and the Orientation and Annual Education Binder - Contract Staff were reviewed with the ADOC. Six of the staff identified as agency PSW's: #200, #201, #202, #203, #204, #205, and four agency registered staff #206, #207, #208 and #209 who were noted as having worked during an identified time period did not have dates and signatures documented indicating they had reviewed the required orientation material. The ADOC confirmed the agency staff noted above did not receive the required training prior to performing their responsibilities as noted above.

This area of non-compliance was identified in relation to CI inspection #020603-18; complaint inspections #018920-18; #018378-18; #018113-18 and #016094-18. [s. 76. (2)]

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: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

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

Park Lane Terrace is a 132 bed capacity LTC home with approximately 24 to 30

residents in each of the five home areas. The Ministry of Health and Long-Term Care (MOHLTC) received complaints including, #016094-18; #018007-18; #018113-18; #018378-18; #018920-18 and #012534-18 about inadequate nursing department staffing in the home which was impacting the personal care and services provided to the residents including: continence care; dressing and grooming and hygiene. Inspectors arrived at the home on July 12, 2018 and for approximately two weeks they received additional complaints related to lack of sufficient nursing department staffing which resulting in residents not being provided aspects of personal care.

On an identified date in August 2018, Corporate staff #120, the DOC and the ADOC confirmed that aspects of personal care and morning between-meal beverages and nourishments were not being provided to residents due to inadequate nursing department staffing. The home submitted CI report #2779-000019-18 to the MOHLTC on that day reporting staff to resident neglect of residents #053, #054, #055, #056, #057 and #075. The CI report indicated aspects of personal care and morning between meal beverages and nourishments were not provided to residents over the previous twelve weeks due to inadequate nursing department staffing.

The staffing shortages took place during the twelve weeks prior to the identified date as confirmed with Corporate staff #120, #128, the DOC, the ADOC and the Staffing Clerk. They reported the home made changes to the nursing department staffing from April 2018 to July 2018. Corporate staff #128 reported that in April 2018, the home made reductions in the nursing department staffing plan after the Case Mix Index (CMI) was reduced. The home's corporate office was aware of this change and the plan was that the home would gradually increase the nursing department staffing as funds became available through the year. It was reported that the former Administrator independently made further changes to the staffing plan which included creating shorter shifts that were difficult to fill and changing or deleting some shifts which resulted in a staffing mix which did not meet the assessed needs of the residents and the staff could not provide adequate care to the residents. There were not enough nursing staff on the day and evening shifts to provide the care the residents needed.
The staffing pattern that impacted the residents noted in the CI report, who did not receive the nourishments and other aspects of personal care was in effect in July 2018.
The home's April 2018 staffing plan, prior to the changes and the July 2018 staffing plan that was in effect at the beginning of the inspection were reviewed

with the Staffing Clerk.

It was noted that in April 2018, the home's nursing department staffing pattern provided: six registered staff and 21 PSWs during the day shift; five registered staff and 14 PSWs during the evening shift and two registered staff and eight PSWs during the night shift.
The July 2018, the staffing plan indicated that there were five registered staff and 17 PSWs working during the day shift; five registered staff and 11 PSW staff during the evening shift and two registered staff and eight PSWs during the night shift as confirmed with the Staffing Clerk.
This represented a decrease in one registered staff and four PSW staff for the day shift, and a decrease of three PSW staff during the evening shift.

On identified home areas, the changes from April 2018 to July 2018, included a two hour reduction in registered nursing hours and a reduction of nine PSW staffing hours during the day shift. Also, there was one PSW working by themselves on identified home areas alone for half an hour each day at an identified time.
On another home area during the day shift, the registered staffing hours were extended by two hours. The PSW hours were reduced by eight hours and there was one PSW on the home area at an identified time.
On another home area there was a reduction in nursing and PSW hours as well. The changes in the home's nursing department staffing plan from April 2018 to July 2018 resulted in fewer registered nursing hours and fewer PSW hours. It also resulted in one PSW working between identified times on four of the five home areas.

On an identified date in July 2018, a specified staff member was observed to be wearing 'scrubs'. When questioned by the inspectors (#506, #123 and #156) as to why they were wearing scrubs, the specified staff member responded that "they were acting as a PSW today". PSW #110 and #109 confirmed that the specified staff member did this approximately once per month which was also confirmed by the Administrator. The Employee Services Coordinator confirmed that they were short staffed on the identified date in July 2018.

The home's nursing department staffing plan was reviewed and the staff deployment was observed throughout the home on multiple occasions during the inspection. Registered staff, PSWs, the home's nursing department management and corporate staff confirmed the home's staffing plan did not provide a staffing

mix that was consistent with residents' assessed care and safety needs. As a result of the nursing department staff shortages residents did not receive the personal care they required.

The internal staff bulletin board was observed and there were nine job postings for PSW staff: one full-time and eight part- time. Corporate staff #128 reported that in order to meet the care needs of the residents, an additional 10 to 15 staff members, including five RPNs and two RNs were required. Shortage of staff would be addressed by utilizing an identified staffing agency for non-registered nursing department staff. Corporate staff #128 and the DOC also reported the home would immediately start calling applicants for interviews for the positions that were already posted to the public. On-boarding could take up to six weeks and staff would start as soon as possible if all police checks were completed.

This area of non-compliance was identified CI inspection #020603-18; complaint inspections #018920-18; #018378-18; #018113-18 and #016094-18 which were included in this inspection.

PSWs reported to the Inspector that they did not descale the tubs due to time restrictions. According to several housekeeping staff, the tub rooms and soiled utility rooms were not cleaned due to cuts in housekeeping hours, if they were running behind schedule due to cleaning emergencies, or having been asked to assist PSWs with tasks such as portering residents to dining rooms, assisting with meals, assisting with resident's lifts and transfers and other duties not specifically assigned.

The staffing plan did not provide for a staffing mix that was consistent with residents' assessed care and safety needs:

A) The home submitted a CI report #2779-000019-18 to the MOHLTC on an identified date in August 2018, reporting improper/incompetent treatment of six identified residents which they attributed to nursing department staffing shortages over a twelve week period. It was noted that two days prior, the DOC and ADOC were present when it was noticed that there were residents missing from the breakfast area. PSW #111 was questioned and they reported that due to staff shortages they were not able to get all of the residents up for breakfast. PSW #111 reported residents #053, #054, #055, #056, #057 and #075 were in bed because they did not have time to provide care to them. PSW #111 reported they had been told they were exempted from doing the snack cart twelve weeks prior

by the former Administrator and former DOC. PSWs, registered staff, the ADOC, DOC and corporate staff #128 confirmed the information as noted in the CI report.

The home’s staffing pattern for the twelve week period ending on an identified date in August, 2018 did not meet the assessed care needs of residents #053, #054, #055, #056, #057 and #075.

B) Resident #072 reported to the Inspector that they were not provided care to manage their incontinence as required between identified hours daily because the home did not have enough staff available as the staff could not leave the dining room during the daily meal service.

The home’s nursing and personal support staffing plan was reviewed. The nursing and personal support staffing deployment in the dining room was observed on multiple occasions throughout the inspection.

Registered staff #123 was interviewed and reported that resident #072 had incontinence and required the assistance of staff. The staff could not leave the dining room during meals because they had to serve, feed and supervise the residents. They confirmed resident #072 was not toileted during identified hours as there were not enough nursing and personal support staff available to do so.

The home did not ensure that the nursing and personal support staffing plan provided for a staffing mix that was consistent with resident #072's assessed care and safety needs.

This area of non-compliance was issued in relation to Complaint inspection #018920-18.

C) On an identified date in July 2018, resident #060 was observed by the inspector to have signs of incontinence. The resident was observed again an hour and a half later where it was noted the resident still had signs of incontinence. A review of the clinical record related to continence care confirmed that the staff were to check resident #060 for wetness due to urinary incontinence and toilet the resident if they were wet. An hour and a quarter later, the resident was again observed and it was noted that the resident still exhibited signs of urinary incontinence including wetness. Interview with RPN #106 confirmed that the resident was to be checked for wetness at an identified time and confirmed resident #060 demonstrated signs of urinary incontinence. PSW #105 confirmed

resident #060 was not checked for incontinence or toileted as directed by their care plan due to the unit being short staffed. (506)

D) Resident #040 was observed covered in a hospital gown and blanket on an identified date in July 2018 until after lunch by inspectors #156 and #506 at two different times of day. A review of the plan of care for this resident did not indicate that it was their preference not to be dressed. PSW staff #111 and #117 confirmed that the resident was not dressed that day until after lunch as they were short staffed. The home did not ensure that the nursing and personal support staffing plan provided for a staffing mix that was consistent with resident #040's assessed care and safety needs.(156)

E) During the inspection, it was reported to the Inspector that resident #015 was left in their pajamas.

On an identified date in August 2018, resident #015 was observed in their pajamas and a robe in the afternoon. PSW #138 reported the resident was not dressed because it was their bath day. The home was understaffed and there was not enough time. The DOC observed resident #015 dressed in pajamas and a robe and confirmed the resident was not assisted in getting dressed as required.

F) Bathing was not offered twice a week due to staffing shortages:

a) In an interview with PSW #144 on an identified date in July 2018, it was reported that the home was short staffed and residents who had scheduled baths on the identified home areas on two identified dates in July, 2018, did not receive baths as well as the resident who had baths scheduled on another identified date in July, 2018.

b) The "Daily Assignment Sheets" were reviewed from identified dates in July 2018. In addition to the staff shortages noted above, the following staff shortages were confirmed with the Employee Services Coordinator on August 16, 2018.

On two home areas:
i) On three identified dates in July 2018, no PSW staff were available for bath shift from 0600 to 1200 hours.
ii) On two identified dates in July 2018, no PSW staff were available for the bath shift from 1430 to 2100 hours.

iii) On one identified date in July 2018, short one PSW from 0630 to 1430 hours.

On three other home areas:
i) On three identified dates in July 2018, no PSW staff were available for the bath shift from 0600 to 1400 hours.
ii) On one identified date in July 2018, no PSW staff were available for the bath shift from 1300 to 2100 hours.

In an interview with RPN #142 and PSW #144 it was reported that residents scheduled baths were often missed when scheduled bath shift PSWs were not available. It was reported that the home did not have a process in place to make up/reschedule residents missed baths.

The following shift shortages were also confirmed on the units listed:
iii) On an identified date in July 2018, short one PSW staff on an identified home area from 0600 to 1400 hours.
iii) On an identified date in July 2018, short one PSW staff on an identified home area from 0600 to 1400 hours.
iv) On an identified date in July 2018, short one PSW staff on an identified home area from 0600 to 1400 hours.
v) On an identified date in July 2018, short one PSW staff on an identified home area from 0630 to 1430 hours.
vi) On an identified date in July 2018, short one PSW staff on an identified home area from 0600 to 1400 hours.

In an interview with RPN #142 as well as in interview with PSW #144 it was reported that when there were shortages on the unit, the scheduled bath shift PSW would be required to assist with other resident care responsibilities and scheduled baths were not be completed. (583)

c) Staff were to refer to a "Bathing List" for frequency and specific dates for resident #057. The resident confirmed that they preferred to have a bath on identified days of the week, but on certain days, due to short staffing, they did not get a bath on their preferred days. The resident stated that they received a bath on an identified date in September 2018, but no other baths for two weeks prior.

The home did not ensure that the nursing and personal support staffing plan provided for a staffing mix that was consistent with resident #057's assessed care and safety needs. (123) [s. 31. (3) (a)]

2. The home was requested to produce the written record of the 2018 Annual review of the Nursing and Personal Support Program. The home provided the 2017 Staffing Plan Review and Evaluation, dated January 2017. Corporate staff #128 and#130 reported the former Administrator was to have evaluated the home's Nursing and Personal Support Program in April 2018. They reported they could not locate the home's record. [s. 31. (4)]

Additional Required Actions:

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written record is kept relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes are implemented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a

minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) In an interview with resident #156, they reported that they did not receive a bath on an identified date in July, 2018. The resident confirmed they were not offered a rescheduled bath.

In an interview with PSW #144, they confirmed resident #156's bath was not completed or rescheduled. PSW #144 also reported that residents who had scheduled baths on identified home areas on two identified dates in July, 2018 were not completed as well as the scheduled baths on another identified date in July, 2018.

Point of Care (POC) bathing documentation was reviewed for the dates and times identified above where PSW #144 identified resident bathing was missed.

i) On an identified date in July, 2018, there was no documentation that resident #101, #102 and #104 scheduled baths were completed or offered and there was no documentation to show their baths were rescheduled.

ii) On an identified date in July, 2018, there was no documentation that resident #007, #105, #106, #107 and #004's scheduled baths were completed or offered and there was no documentation to show the baths were rescheduled. It was documented that two identified residents received a bed bath instead of their preferred choice.

iii) On an identified date in July, 2018, there was no documentation that resident #108, #062, #109, #110, #111, #112, #113 and #114's scheduled baths were completed or offered and there was no documentation to show their baths were rescheduled.

The residents did not receive a bath a minimum of twice per week during the identified time period.

In an interview with resident #156, PSW bathing staff #144 and through a review of the bathing documentation in POC, it was confirmed that not all residents were being bathed a minimum of two times per week. (583)

B) Staff were to refer to a “Bathing List” for frequency and specific dates for bathing for resident #057. The resident confirmed that they preferred to have a bath on identified days of the week, but on certain days, due to short staffing, they did not get a bath on their preferred days. The resident stated that they received a bath on an identified date in September, 2018, but no other baths for two weeks prior.

The POC bathing documentation "Follow-up Question Report" for the period of twelve identified dates in September, 2018, revealed that staff #167 documented on an identified date in September, 2018, “not applicable” and a staff member documented that the resident refused their bath on another identified date in September, 2018. No other documentation was made as to whether the resident received a bath, shower or bed bath during this time period. (120)

C) CI report #2779-000018 submitted to the MOHLTC was reviewed. The clinical records including the care plans, progress notes and the May, June and July 2018 , POC documentation of residents #053, #054, #055, #056, #057 and #075 were reviewed. All residents were noted to require the assistance of staff for transfers and bathing.

The review of the May 2018, POC documentation indicated:
i) Resident #053 received five baths and not applicable was indicated six times.
ii) Resident #055 received seven baths and not applicable two times.
iii) Resident #075 received six baths; refused one bath and not applicable was noted four times.

The review of June 2018, POC documentation indicated:
i) Resident #053 received six baths and not was not applicable seven times.
ii) Resident #054 received four baths; refused two baths; not applicable noted for one bath; not available for one bath and no documentation with blank space observed for one bath.
iii) Resident #055 received five baths and not applicable noted two times.
iv) Resident #057 received three baths; refused three baths and not applicable once.
v) Resident #075 received four baths and not applicable was noted four times.

The review of the July 2018, POC documentation indicated:
i) Resident #053 received seven baths; not applicable four times.
ii) Resident #054 received six baths and not applicable was noted three times.

iii) Resident #055 received five baths and not applicable five times.
iv) Resident #056 received seven baths and not applicable once.
v) Resident #076 received six baths and not applicable was noted two times.

Interview with PSW's and the DOC confirmed each resident of the home was not bathed, at a minimum, twice weekly by the method of their choice.

Through completion of interviews with residents and staff, reviews of Point of Care documentation and reviews of staff shortages on the daily assignment sheet it was confirmed that each resident in the home was not being bathed a minimum of twice per week. [s. 33. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Critical incident (CI) report #2779-000020-18 submitted to the MOHLTC in relation to an alleged incident of improper care on an identified date in August 2018, was reviewed. The clinical record of resident #041 including the progress notes were reviewed. Resident #041 required a specific level of assistance for transfers. On an identified date in August 2018, resident #041 required personal care and registered staff #101 was assisting PSW #110 to facilitate the provision of care. The resident sustained a fall which resulted in injury. Interview with PSW #110, confirmed that staff did not use safe transferring and positioning devices or techniques when they failed to provide the required level of assistance when providing care to resident #041.

This area of non-compliance was identified in relation to CI inspection #020604-18. [s. 36.]

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: CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Critical incident (CI) report #2779-000020-18 submitted to the MOHLTC in relation to an alleged incident of improper care on an identified date in August 2018, was reviewed. The clinical record of resident #041 including the progress notes was reviewed. Resident #041 fell on an identified date in August 2018. As a result, the resident sustained injury. As confirmed with the DOC, a skin assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

This area of non-compliance was identified in relation to CI inspection #020604-18. [s. 50. (2) (b) (i)]

2. During the inspection, resident #072 complained to the Inspector that whenever they required personal care between identified hours they were put at risk for skin breakdown.

The clinical record of resident #072 was reviewed including the progress notes and care plan. Progress note documentation of an identified date in May 2018, indicated there was an area of altered skin integrity which the staff treated. The early morning documentation of an identified date in July 2018, indicated the resident reported to the staff they were uncomfortable and treatment was applied. That evening the area of altered skin integrity was observed and the area was washed and a treatment was applied. Progress note documentation on the following day indicated the area on the resident was noted to be worsening in condition. The area was cleaned and treatment was applied.

There was no documentation found in the resident’s record of a skin assessment completed for the area of altered skin integrity identified on the identified date in July 2018, by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. Registered staff #123 reviewed the clinical record of resident #072 and confirmed there was no assessment of the altered skin integrity on the resident.

Registered staff #123 reported the resident had a history of altered skin integrity which would resolve and return. The registered nursing staff who documented concerning the altered skin integrity confirmed they should have completed a skin assessment and initiated a Treatment Administration Record (TAR) and then the area should have been assessed weekly. Registered staff #123 reviewed the clinical record of resident #072 and confirmed the altered skin integrity on resident #072 was not assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. (123)

This area of non-compliance was identified in relation to Complaint inspection #018920-18. [s. 50. (2) (b) (i)]

3. On an identified date in September 2018, the ADOC verified that the expectation was that all areas of altered skin integrity would be recorded in the resident’s clinical record in Point Click Care (PCC), assessment tab, under wound assessments when the area of altered skin integrity was discovered.

A review of the clinical record for resident #200 identified that the resident had an area of altered skin integrity. A review of the clinical record did not include an assessment of the area of altered skin integrity using a clinically appropriate

assessment. On an identified date in August 2018, it was documented that the resident had multiple areas of altered skin integrity. The clinically appropriate assessment was initiated but only discussed the measurements of one of the four areas identified. On an identified date in September 2018, the ADOC confirmed that the resident did not have an assessment of all the identified areas of altered skin integrity completed, as required when the areas were first identified using a clinically appropriate assessment instrument. (506)

This are of non-compliance was identified in relation to Complaint inspection #012534-18. (506) [s. 50. (2) (b) (i)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)

The following order(s) have been amended: CO# 005

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) A review of the home's medication incidents for the second quarter was completed. This review included an Incident Report for an identified date in May 2018, regarding a scheduled medication which was not administered to resident #071.

The Incident Report identified that resident #071 did not receive a scheduled dose of medication on an identified date in May 2018, at an identified time as prescribed by their physician. The medication was found in its dated and timed package in the locked medication cart seven and a half hours later. At this time it was noted by staff #123 that the medication remained in its package.

A review of the clinical record identified that resident #071 was monitored for identified symptoms, after the error was identified. As documented in the progress notes resident #071 was experiencing identified symptoms on this date. The resident received an as needed (PRN) dosage of an analgesic medication at an identified time with good effect as documented in the electronic Medication Administration Record (eMAR).

A review of the May 2018, eMAR identified that a signature was not in place on the identified date and time in May 2018, as required, to identify that the medication was given.

Interview with registered staff #123, identified that they found the medication in the medication cart at the end of their shift on the same date. Registered staff #123 reported that they completed the incident reports and notified the physician. They also reported that the resident received an identified PRN medication along with increased monitoring after the incident.

Interview with the Resident Assessment Instrument (RAI) Coordinator #131, identified that based on their internal investigation, resident #071, on the identified date and time, did not receive their medication as prescribed.

Drugs were not administered to resident #071 in accordance with the directions for use specified by the prescriber. (674)

B) A review of the home's medication incidents for the second quarter was completed. This review included an Incident Report, for an identified date in May 2018 regarding scheduled medications which were not administered to resident #070.

The Incident Report identified that resident #070 did not receive scheduled dosages of two medications on an identified date in May 2018, at an identified time as prescribed by their physician. The medications were found in their dated and timed package in the medication cart the following day. A review of the incident report identified that the resident did not have any indication of harm as a result of the incident. The clinical record of resident #070 was reviewed including the progress notes and assessments documented that the resident did not have any adverse reactions as a result of the missed medications.

Interview with registered staff #116 identified that they found the medications in the medication package. They reported that they completed the incident reports and assessed the resident.

Interview with the RAI Coordinator #131 identified that based on their internal investigation, resident #070, did not receive their prescribed medication.

Drugs were not administered to resident #070 in accordance with the directions for use specified by the prescriber. (674)

C) Critical incident (CI) report #2779-000027-17 was submitted to the MOHLTC on an identified date in October 2017, in relation to two of resident #082's identified medications missing.

The clinical record for resident #082 was reviewed including the progress notes. A medication progress note dated for an identified date in October 2017, at an identified time stated that the PSW informed them that the medication was not administered during morning care. A progress note indicated that the resident was due to have their medication that shift. Registered staff #158 attempted to administer the medication but identified it missing from the medication cart.

Interview with registered staff #158 reported that on the identified date in October 2017, they reported the missing medication to the DOC who reported the concern to the pharmacist.

D) Resident #082 had a physician's order dated for an identified date in September 2017, for a medication.

During interview with registered staff #147, they indicated that resident #082 had

missing medication, however, they were unable to recall whether resident #082 was due for medication or if it had been administered earlier. During the inspection, it was noted on the "Monitored Medication Record" that the medication was administered on the evening of an identified date in October 2017, twenty four hours earlier. Registered staff #147 stated they administered another medication when it was found missing according to their progress note which was approximately five and a half hours after shift change the last time the medication was identified as present.
Registered staff #147 reported, that the missing medication was not reported to the DOC.

The home's records including the "Shift Change Monitored Medication Count" from identified dates in October 2017 to January 2018, were reviewed. It was noted that on an identified date in October 2017, the count which had been completed by two registered staff, stated that resident #082 did not have a medication administered. Registered staff #101 reported that they were unable to locate the medication so another one was administered. They also reported that the missing medication was not reported to the DOC. The "Monitored Medication Record" was reviewed. It was noted that a medication was administered on the evening of an identified date in October 2017, twenty four hours earlier.

The home failed to ensure that resident #082's medication was administered to the resident in accordance with the directions for use specified by the prescriber. (536)

This area of non-compliance was identified in relation to CI inspection #021539-18.

E) CI report #2779-000030-17 submitted to the MOHLTC on an identified date in December 2017 in relation to two of resident #081's identified medications missing.

The clinical record for resident #081 was reviewed including the progress notes. The physician's order indicated that resident #081 was to be administered a medication.

The home's records including the "Monitored Medication Record" were reviewed. The record indicated that medication was administered on an identified date in

December 2017, to resident #081's by registered staff #122.

A review of the progress notes written for an identified date in December 2017, indicated that registered staff #142 and two other staff were unable to locate the resident's medication at that time. PRN analgesic medication would be offered until a new medication was administered or the previous medication was located.

Progress notes of an identified date in December 2017, indicated that registered staff #142 was not able to locate the medication as prescribed and a new medication was administered to the resident.

The home failed to ensure that resident #081's medications were administered to the resident in accordance with the directions for use specified by the prescriber. (536)

This area of non-compliance was identified in relation to CI inspection #028494-17. [s. 131. (2)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 006

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

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

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

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

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a minimum of three meals daily.

A) An observation of the meal service was completed in identified dining rooms on an identified date in July, 2018. It was noted that a number of residents were absent from the dining room for the meal service. Inspector #583 was present until the end of the dining service at which time it was observed food was removed from the servery and no trays were prepared for room service.

After the service was completed interviews were conducted with RPN #142 and #126, as well as with PSW's #143, #134 and #144 who were all present for the meal service. Through observations and interviews with the staff it was confirmed that residents #073, #074, #090, #091, #092, #093, #094 and #097 were not present in the dining room for the meal and were not offered a meal tray. Resident #073, #074, #090, #094 and #097 were all assessed as being at an identified nutrition risk.

Interview with RPN's #126 and #142, reported that the homes' expectation was that meals were to be provided in the dining room, there was not typically a meal tray service for residents and no enhanced snacks or special dietary interventions were in place for missed meals. In interviews completed with registered nursing staff and PSW's, it was reported that not all residents were brought to the dining room for meal service on all units on a regular basis and tray service was not usually provided.

The "Dietary" care plan interventions were reviewed for all the residents noted above and none identified that it was part of their plan of care not to receive the meal nor were any dietary interventions in place for missed meals.

The "Daily Assignment Sheet" was reviewed and it was confirmed with the Employee Services Coordinator, that there were no staff shortages in the home on the identified date. (583)

B) A complaint was received by MOHLTC on an identified date in June, 2018, alleging that residents were not receiving three meals per day. An observation of the lunch meal service was completed in the home area dining room on an identified date in July, 2018. Residents #073 and #002 were not present for the meal service and meal trays were not made up and offered to them at the end of the service.

At the end of meal service, Inspector #674 noted resident #073 and #002 were in bed. Interview with PSW #134 at 1345 hours by Inspector #674 confirmed that both residents were not offered a meal tray.

Interviews completed with registered nursing staff and PSW's on an identified date in July, 2018, confirmed that not all residents in the home were offered three meals per day. (583)

This area of non-compliance was identified in relation to Complaint inspection #012432-18.

C) A complaint was received by MOHLTC alleging that resident #098 was not provided a meal on an identified date in August, 2018. A review of the clinical record confirmed resident #098 was only offered two meals on that date. An interview with the DOC/Acting Administrator confirmed that resident #098 was not

provided three meals per day .(506)

This area of non-compliance was identified in relation to Complaint inspection #006339-18 (506) [s. 71. (3)]

2. The licensee failed to ensure that each resident was offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and (c) a snack in the afternoon and evening.

A) On two identified dates in July, 2018, inspector #156 identified residents of a home area were not being offered a minimum of a, between-meal beverage in the morning and a beverage and snack in the evening after dinner. This information was confirmed by PSW #111, #112 and #117 and was brought to the attention of the management at that time. (156)

B) Seven days later, inspector #583, identified ongoing concerns related to residents on the home area not being offered a between meal beverage in the morning and a between meal beverage and snack in the afternoon and evening. This was confirmed by interview of PSW staff working on the home area and the Food Services Manager (FSM).

C) The following week, the non-compliance was again identified by inspector #123 as the residents of a home area had not received a between meal beverage in the morning. This was confirmed during interviews with PSW staff and the DOC. The DOC indicated to the inspector that the afternoon and evening beverages and snacks would be provided to the residents.

D) On an identified date in August, 2018, PSW staff on a home area informed inspector #674 that residents of that home area were not offered a between-meal beverage that morning. The corporate staff #128 also confirmed residents of another home area were not provided a between-meal beverage in the morning of an identified date in August, 2018.

E) The following day, the home submitted CI report #2779-000018-18 to the MOHLTC which was reviewed. It was noted that on an identified date in August, 2018, the management noticed that not all residents were in the dining room for breakfast. When the staff were questioned they reported that due to staff shortages they were not able to get all residents up for breakfast. Staff were instructed to get all residents up. Staff reported the residents were in bed

because they did not have time to provide care to them. The management inquired about the nourishment cart and whether between-meal beverages were being provided to residents. Staff informed the management staff that they did not do that and explained the staff had been told they were exempted from the snack cart for 12 weeks by the former DOC and former Administrator. (123)

PSWs, registered staff the DOC, ADOC and corporate staff #128 confirmed the residents were not offered a between-meal beverage in the morning as indicated above.

This area of non-compliance was identified during complaint inspections #018113 -18, #018378, 016094-18 and CI inspection #020603-18 which are included in this inspection.

F) A review of the July 2018, POC documentation related to morning nourishment of the residents noted in CI report #2779-000019-18 indicated:

i) Resident #053 received morning nourishments 16% of the time. Not applicable (which meant that the resident did not receive the nourishment) was documented 48% of the time and no documentation with blank spaces observed on the remaining days.

ii) Resident #054 received morning nourishments 6% of the time. Not applicable was noted 54% of the time and no documentation with blank spaces observed 39% of the time.

iii) Resident #055 received morning nourishments 10% of the time. Not applicable was noted 32% of the time and no documentation with blank spaces observed 58% of the time.

iv) Resident #056 received morning nourishments 10% of the time. It was noted as not applicable 58% of the time and no documentation with blank spaces observed 32% of the time.

v) Resident #057 received morning nourishments 3% of the time It was noted as not applicable 56% of the time; noted as resident refused 6% of the time; resident not available 3% of the time and no documentation with blank spaces observed 9% of the time.

vi) Resident #075 received morning nourishments 10% of the time. It was noted as not applicable 51% of the time; resident refused 3% of the time and no documentation with blank spaces observed 35% of the time.

The licensee failed to ensure that each resident was offered a between-meal beverage in the morning, afternoon and evening after dinner; and a snack in the afternoon and evening. (123) [s. 71. (3)]

3. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack.

The therapeutic menu for an identified date in July, 2018, indicated that puree wheat bread was to be available for those residents on a puree textured diet. During the lunch meal observation on an identified home area on an identified date in July, 2018, it was noted that the puree textured bread was not available as confirmed with dietary aide #100. [s. 71. (4)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

(A1)

1. The licensee failed to ensure that residents were protected from abuse by

anyone.

The O. Reg 79/10, s. 2 (1) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident 's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

The O. Reg 79/10, s. 2 (1) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are preformed by anyone other than a resident.

1. Critical incident (CI) report #2779-000008-18 submitted to the MOHLTC in relation to an alleged abuse incident of an identified date in April 2018, was reviewed. The clinical record of resident #004 including the progress notes was reviewed. Progress note documentation of May 2018, indicated the resident reported to staff that an identified person made a threat of retaliation in relation to an alleged abuse incident. Progress notes for an identified date in May 2018, indicated the resident reported to the staff that another identified person made an abusive comment in relation to the same incident. The resident was noted to have been emotionally upset by these occurrences.

Social worker records noted that resident #004 was involved in an incident which increased their emotional symptoms.

The DOC/Acting Administrator confirmed resident #004 was not protected from verbal and emotional abuse.

The review of resident #004's progress notes indicated that on an identified date in August 2018, the resident reported to the registered staff an allegation of potential abuse. The registered staff was noted to have provided support to resident #004 and stated they would speak to the DOC the following day.

The Assistant Director of Care (ADOC) and Corporate staff #128 were interviewed and reported the resident was upset by the interaction. The alleged interaction met the home's definition of emotional abuse. The home notified the police of the allegation of abuse.

The home did not protect resident #004 from verbal and emotional abuse.

This area of non-compliance was identified in relation to CI inspection #009768-18. [s. 19. (1)]

2. The licensee failed to ensure that residents were protected from abuse by anyone.

O. Reg. 79/10 s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Critical Incident (CI) report #2779-000025-18 submitted to the MOHLTC on an identified date in August 2018, was reviewed. It indicated that on that date, resident #095 was involved in an incident with resident #103 that resulted in injury. The police were notified of the incident. The home’s investigative records and the residents’ clinical records were reviewed. Resident #103 confirmed the incident occurred as noted above. The DOC was interviewed and confirmed the accuracy of the information as documented in the CI report.

The home did not ensure that resident #103 was protected from physical abuse by resident #095.

This area of non-compliance was identified in relation to CI inspection #022874-18. [s. 19. (1)]

3. The licensee failed to ensure that residents were protected from abuse by anyone.

O. Reg. 79/10 s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Critical Incident report #2779-000022-18 submitted by the home to the MOHLTC on an identified date in August 2018, was reviewed. It indicated that on that date, resident #095 was involved in an incident with resident #101 that resulted in injury. The residents’ clinical records and the home’s investigative records were reviewed and indicated information as contained in the CI report. The DOC confirmed the accuracy of the information in the CI report.

The home did not ensure that resident #101 was protected from physical abuse

by resident #095.

This area of non-compliance was identified in relation to CI inspection #021738-18. [s. 19. (1)]

4. The licensee failed to ensure that residents were not neglected by the licensee or staff.

According to O. Reg. 79/10, s. 5 neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents.

1) Residents did not receive assistance with toileting and/or continence care as required:

A) Resident #072 who required assistance with toileting and or continence care was not provided care between identified times. As a result, the resident was identified with a skin breakdown. Registered staff #123 reported the resident had a history of ongoing altered skin integrity which would resolve and return. Registered staff #123 confirmed that resident #072 required the assistance of staff related to continence care and or toileting as per the plan of care. They confirmed when resident #072 was required assistance related to continence care and or toileting between the identified hours, they were not provided the required assistance.

B) On an identified date in July 2018, resident #060 was observed by the LTCH Inspector with signs of incontinence. The resident was observed again an hour and a half later and it was noted the resident still had signs of incontinence. A review of the clinical record related to continence care confirmed that the staff were to check resident #060 and provide specified assistance. An hour and a quarter later, the resident was again observed and it was noted that the resident still had not been provided the specified care. Interview with registered nursing staff #106 confirmed that the resident was to be checked at specified times and confirmed resident #060 was incontinent. PSW #105 confirmed resident #060 was not provided specified care related to toileting and or continence as directed by their care plan.

C) On an identified date in August 2018, the LTCH Inspector observed resident

#098 for approximately three hours. During this time, the resident was not provided specified care. A review of the resident's plan of care under the PSWs tasks confirmed that the resident was to be checked at specified intervals. During interview with PSW #109, they confirmed that they last checked the resident at an identified time and were aware that the resident's plan of care directed them to check at specified intervals. They also confirmed that resident #060 was not checked and or provided care at specified time as required.

2) Residents were not bathed.

A) In an interview with resident #156 on an identified date in July 2018, they reported they did not receive a bath on an identified date in July 2018 and confirmed they were not offered a rescheduled bath.

B) In an interview with PSW #144 on an identified date in July 2018, it was reported that residents who had baths scheduled on identified home areas on two identified dates in July 2018, during identified shifts did not receive baths as well as the residents who had their baths scheduled on another identified date in July 2018, during an identified shift.

C) A review of the Point of Care (POC) documentation for an identified week in July 2018, identified the following:

i) On an identified date in July 2018, there was no documentation found to indicate that resident #101, #102's and #104's scheduled baths were completed or offered and there was no documentation indicating their baths were rescheduled.
ii) On another identified date in July 2018, there was no documentation found to indicate that residents #007, #105, #106, #107 and #004's scheduled baths were completed or offered and there was no documentation indicating their baths were rescheduled. It was documented identified residents received a bed bath instead of their preferred choice.
iii) On another identified date in July 2018, there was no documentation that residents #108, #062, #109, #110, #111, #112, #113 and #114's scheduled baths were completed or offered and there was no documentation indicating their baths were rescheduled.
Through completion of interviews with residents and staff, reviews of Point of Care (POC) documentation and reviews of staff shortages identified on the daily assignment sheets, it was confirmed that each resident in the home was not being

bathed a minimum of twice per week. (583)

D) The plan of care for resident #057, indicated that they required assistance with bathing and referred to a "Bathing List" for frequency and specific dates. The resident confirmed that they preferred to have a bath on specific days and times of the week, but on certain days, they did not receive a bath on their preferred days. The resident stated that they received a bath on an identified date in September 2018, but no other baths for two weeks prior. (120)

E) CI report #2779-000019-18 submitted to the MOHLTC was reviewed. The clinical records including the care plans, progress notes and the May, June and July 2018, POC documentation of residents #053, #054, #055, #056, #057 and #075 were reviewed. All residents were noted to require the assistance of two staff for transfers and one staff for bathing.

The review of the May 2018, POC documentation indicated:
i) Resident #053 received five baths and not applicable was indicated six times.
ii) Resident #055 received seven baths and not applicable two times.
iii) Resident #075 received six baths; refused one bath and not applicable was noted four times.
The review of June 2018, POC documentation indicated:
i) Resident #053 received six baths and not was noted not applicable seven times;
ii) Resident #054 received four baths; refused two baths; not applicable noted for one bath; not available for one bath and no documentation with blank space observed for one bath;
iii) Resident #055 received five baths and not applicable noted two times;
iv) Resident #057 received three baths; refused three baths and not applicable once and
v) Resident #075 received four baths and not applicable was noted four times.
The review of the July 2018, POC documentation indicated:
i) Resident #053 received seven baths; not applicable four times;
ii) Resident #054 received six baths and not applicable was noted three times;
iii) Resident #055 received five baths and not applicable five times;
iv) Resident #056 received seven baths and not applicable once and
v) Resident #076 received six baths and not applicable was noted two times.

Interview with PSWs and the DOC confirmed each resident of the home did not receive bathing a minimum of twice per week. The licensee failed to ensure that

residents were not neglected in relation to bathing.

The MOHLTC received complaints #018920-18; # 018387-18; #018113-18 and #016094-18 regarding the lack of care for the residents. The complaints were reviewed and the complainants were interviewed. They reported information as contained in the complaints.

3) Residents were not offered three meals daily.

A) An observation of meal service was completed in identified home area dining rooms on an identified date in July 2018. It was noted that resident #073, #074, #090, #091, #092, #093, #094 and #097 were not present in the dining room for the meal and were not offered a meal tray.

Registered nursing staff #126 and #142 were interviewed and they reported that the homes' expectation was that meals were to be provided in the dining room, tray service was not provided for residents for missed meals. In interviews with registered nursing staff and PSWs it was reported that, on a regular basis, not all residents were brought to the dining room for meal service on all home areas. (583)

B) The meal service was observed in a home area on an identified date in July 2018. Residents #073 and #002 were not present for the meal service and meal trays were not made up or available for them at the end of the service.
At the end of lunch service Inspector #674 noted resident #073 and #002 were in bed. Interview with PSW #134 by LTCH Inspector #674 confirmed that both residents were not offered a meal tray. (583)

C) A complaint was received by MOHLTC on an identified date in August 2018, alleging that resident #098 was not provided an identified meal on an identified date in August 2018. A review of the resident's clinical record confirmed resident #098 was only offered two meals on the identified date. An interview with the DOC/Acting Administrator confirmed that resident #098 was not provided three meals daily.

The licensee failed to ensure that residents were not neglected by the licensee or staff in relation to the provision of three meals daily.

4) Residents were not dressed and or groomed:

A) The Substitute Decision-Maker (SDM) of resident #015 reported that the resident was not always dressed appropriately for the time of day.
The clinical record of resident #015 was reviewed. Progress note documentation indicated that on an identified date in June 2018, the SDM complained that resident #015 was not dressed in their own clothing, appropriate to the time of day. The SDM requested that the resident be dressed prior to the bath unless the bath was at an identified time or immediately after. A note was placed in the communication book to inform staff. The resident’s plan of care was reviewed and it did not include any of the above information as requested by the resident’s SDM. The DOC confirmed the above information was not included in the resident’s plan of care.

B) A complaint received by MOHLTC identified that a visitor was in to see resident #074 on an identified date in June 2018, the resident was still in bed at an identified time and staff were asked to assist the resident with personal care. On an identified date in July 2018, resident #074 was observed in bed and was not assisted to the dining room for breakfast. The progress notes for July 2018, were reviewed and it was noted on an identified number of occasions that the resident had no intake at breakfast. In addition, POC documentation under the “what percentage of the meal was eaten”? section during a 30 day look-back period dated August 2018, indicated that resident #074 was 'not available' for an identified number of meals. PSW staff reported that they documented 'not available' when residents were not in the dining room for meals and tray service was not provided.

The licensee failed to ensure that residents were not neglected by the licensee or staff in relation to dressing and grooming.

5) Residents were not provided nourishments.

PSW staff reported that they were instructed that for a twelve week period beginning in May 2018, they were exempt from doing the nourishment carts. Residents were not offered between-meal beverages in the morning and afternoon and a beverage in the evening after dinner; and snacks in the afternoon and evening.

Nourishments were not provided as confirmed by the DOC, corporate staff #128, the ADOC as well as noted in CI report#2779-000019-18.

A) In July 2018, LTCH Inspector #156 identified residents of a home area were not being offered a minimum of a, between-meal beverage in the morning and a beverage and snack in the evening after dinner. This information was confirmed by PSWs #111, #112 and #117 and was brought to the attention of the management on an identified date in July 2018. (156)

B) On an identified date in July 2018, LTCH Inspector #583, identified ongoing concerns related to residents on another home area not being offered a between meal beverage in the morning and a between-meal beverage and snack in the afternoon and evening. This was confirmed by interview of PSW staff working on the home area and the Food Services Manager (FSM).

C) On an identified date in August, 2018, the non-compliance was again identified by LTCH Inspector #123 as the residents on an identified floor had not received a between meal beverage in the morning. This was confirmed during interview with the DOC.

D) On an identified date in August 2018, PSW staff on a home area informed inspector #674 that residents of that home area were not offered a between-meal beverage that morning. The corporate staff #128 also confirmed residents on an identified floor were not provided a between-meal beverage in the morning that day.

E) On an identified date in August 2018, the home submitted CI report #2779-000018-18 to the MOHLTC which was reviewed. It was noted that on an identified date in August 2018, the management noticed that not all residents were in the dining room for breakfast. Staff reported the residents were in bed because they did not have time to provide care to them. The management staff inquired about the nourishment cart and whether that was being provided to residents. Staff informed the management staff that they did not do that and explained the staff had been exempted from the snack cart for 12 weeks. (123)

PSWs, registered staff, the DOC, ADOC and corporate staff #128 confirmed the residents were not offered a between-meal beverage in the morning as indicated above.

F) A review of the July 2018, POC documentation related to morning nourishment of the residents noted in CI report #2779-000019-18 indicated:

i) Resident #053 received morning nourishments five days. Not applicable was documented on 15 days and no documentation with blank spaces observed on the remaining 11 days;
ii) Resident #054 received morning nourishments on two days. Not applicable was noted on 17 days and no documentation with blank spaces was observed on 12 days;
iii) Resident #055 received morning nourishments on three days. Not applicable was noted on 10 days and no documentation with blank spaces was observed on 18 days;
iv) Resident #056 received morning nourishments on three days. It was noted as not applicable on 18 days and no documentation with blank spaces observed on 10 days;
v) Resident #057 received morning nourishments on one day. It was noted as not applicable on 17days; noted as resident refused on two days; resident not available on one day and no documentation with blank spaces was observed on nine days and
vi) Resident #075 received morning nourishments on three days. It was noted as not applicable on 16 days; resident refused on one day and no documentation with blank spaces observed on 11 days. (123) [s. 71. (3)] (156)

The licensee failed to ensure that residents were not neglected by the licensee or staff in relation to the provision of nourishments.

The licensee failed to ensure that the residents were not neglected by the licensee or staff. [s. 19. (1)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 008

WN #9: 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 failed to ensure that the home was a safe and secure environment for its residents.

A) The record of resident #072 including the progress notes, care plan and Bed Safety Assessment was reviewed. The progress note documentation dated on an identified date in July, 2018, that the resident was moved to an identified room. The bed in the identified room was assessed for entrapment risk. The bed did not have bed side rails; however, zone seven did not pass because the mattress was too short for the bed. The staff informed the SDM of the entrapment issues with the bed and they expressed understanding. The care plan was updated to reflect the risk of entrapment and hourly registered nursing staff checks were initiated on the residents Medication Administration Record (MAR).

The Bed Safety Assessment dated on an identified date in July, 2018, included that the resident was moved to the identified room. The resident was transferred into the bed prior to a safety audit being completed. The Bed Safety Assessment revealed a zone seven failure. The resident was noted as being incapable of making an informed decision about the use of bed rails. The resident was also noted to be at risk for entrapment. The Bed Safety Assessment indicated that staff were to consider entrapment risk and alternatives.

The care plan in effect at the time included a focus of potential for entrapment in zone seven. Interventions included: staff were to aim to use the least restrictive measures while in bed; resident would remain safe while in bed which did not pass zone seven; assessment of bed side rail use by Multidisciplinary Team and resident/SDM when needed if changes occur; bed side rails had been removed; family would be made aware of potential entrapment and risks involved with the resident remaining in an unsafe bed and registered staff would monitor hourly for resident positioning while in bed.

The Director of Environmental Services (DES), ADOC and registered staff #123 reported that the resident used the bed in the identified room which failed the Bed Safety Assessment for entrapment at zone seven. The bed was assessed after the resident was transferred into the bed. No interventions were put into place to correct the failed zone seven to mitigate the resident's risk of entrapment and/or injury.

The home did not provide a safe and secure environment for resident #072 in relation to bed safety. (123)

This area of non-compliance was identified in relation to complaint inspection #018920-18.

B) On an identified date in September, 2018, both a visitor and resident #062 complained to Inspector #156 that a sidewalk near the entry to the back of the home was very uneven in some areas by approximately 2.5 centimetres above the neighboring portion of the sidewalk. The sidewalk in the courtyard off of the main hallway was observed to have three large sections of concrete that were missing. These sections were approximately 25 centimetres by 12.5 centimetres in some areas. The resident complained that they had almost fallen several times. Interview with the ADOC confirmed that the home had been aware of these areas for over three months and they had not been repaired; the uneven and missing concrete areas were not a safe and secure environment for the residents. (156) [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its' residents, to be implemented voluntarily.

WN #10: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) A complaint was received by MOHLTC on an identified date in March, 2018, alleging that resident #098 was not provided specific care and receiving a treatment supplied by the family. A review of the clinical record confirmed that the above interventions had been discussed with the SDM and would be initiated as part of the resident's plan of care. A review of the clinical record did not include these interventions. Interview with the ADOC, confirmed that these interventions were not included in the plan of care and did not set out the planned care for resident #098. (506)

This area of non-compliance was identified in relation to Complaint inspection #006339-18.

B) A falls risk assessment was completed on an identified date in July, 2018, for resident #084 and the resident was deemed to be at an identified risk for falls, however, the written plan of care for the resident did not set out the planned care for the resident in relation to falls prevention. The resident sustained a fall with injury on an identified date in August, 2018, and a falls risk assessment was completed. The resident was now deemed to be at a different risk for falls, however, the written plan of care for the resident still did not set out the planned care for the resident in relation to falls prevention. The plan of care did not include any goals or falls prevention interventions as confirmed with the DOC. (156)

This area of non-compliance was identified in relation to CI inspection #020604-18.

C) The SDM of resident #015 reported to the inspector that the resident was sometimes not dressed appropriate for the time of day.

The clinical record of resident #015 was reviewed. Progress note documentation indicated that on an identified date in June, 2018, the SDM complained that resident #015 was not dressed in their own clothing, appropriate to the time of day. The SDM requested that the resident be dressed prior to their bath unless the bath was at an identified time or immediately after. A note was placed in the communication book to inform staff. The resident's plan of care was reviewed and it did not include any of the above information as requested by the resident's SDM. The DOC confirmed the above information was not included in the resident's plan of care.

The written plan of care did not set out the planned care for the resident in relation to dressing the resident. (123) [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

The clinical record of resident #004 including the RAI-MDS assessments on identified dates in January, 2018 and April, 2018, were reviewed. The resident's behavioural symptoms were noted to have deteriorated in the April, 2018,

assessment compared to the January, 2018 assessment. The RAI-MDS Coordinator confirmed the accuracy of the information documented in the noted RAI-MDS assessments. The resident's care plan was reviewed with the RAI-MDS Coordinator and it did not include a focus related to responsive behaviours. The RAI-MDS coordinator confirmed resident #004's plan of care for an identified date in April, 2018, was not based on an assessment of the resident's needs and preferences related to responsive behaviours. [s. 6. (2)]

3. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given the opportunity to participate fully in the development and implementation of the resident's plan of care.

A) A complaint was received by MOHLTC on an identified date in March, 2018, alleging that resident #098 developed a change in status on an identified date in November, 2017 and the SDM was not notified. A review of the clinical record confirmed that the SDM was not notified of the resident's change in status until an identified date in November, 2018, when the SDM called in to the home for an update. Interview with RPN #116 confirmed that the SDM was not notified of the change in status when it was first identified and were not given the opportunity to participate fully in the development and implementation of the resident's plan of care. (506)

This area of non-compliance was identified in relation to Complaint inspection #006339-18 and a CI inspection #018579-18.

B) Resident #098 sustained an injury on an identified date in July, 2018, due to the resident demonstrating responsive behaviours. Communication was sent to the home on an identified date in July, 2018, from the resident's SDM indicated that they originally denied a referral to an identified agency, however now felt that this referral should be initiated. A review of the clinical record on on an identified date in August, 2018, confirmed this had not been completed or initiated. An interview with the ADOC confirmed that a referral had not been completed and the SDM was not given the opportunity to fully participate in the development and implementation of the resident's plan of care. (506)

This area of non-compliance was identified in relation to Complaint inspection #006339-18 and a CI inspection #018579-18.

C) A complaint received by MOHLTC identified that the complainant was in to see resident #074 on on an identified date in June, 2018, and the resident was still in bed at an identified time and staff had to be asked to assist the resident with personal care. On on an identified date in July, 2018, resident #074 was observed in bed at an identified time and was not taken to the dining room for a meal. The progress notes documented multiple times that the resident had not eaten anything at an identified meal over an identified period of time in July, 2018. In addition, POC documentation under the "what percentage of the meal was eaten" section during a 30 day look back period dated August, 2018, indicated that resident #074 was not available for multiple meals. PSW staff reported that they document this way when residents were not in the dining room for meals and tray service was not provided.

Resident #074 could not identify their preferences related to meals. In an interview with resident #074’s SDM, it was reported that were under the understanding the resident was being offered three meals per day.

On an identified date in August, 2018, a new task was created in resident #074’s plan of care related to meals however, the Registered Dietitian (RD) reported that they were not aware this intervention was in place and that it was not done in consultation with an RD.

On on an identified date in August, 2018, resident #074’s SDM reported that they were not aware of this intervention and were not given an opportunity to participate in the development of the resident’s plan of care. The RAI Coordinator confirmed that the SDM was not given an opportunity to participate in resident #074’s plan of care. (583)

This area of non-compliance was identified in relation to Complaint inspection #012432-18.

D) The clinical record of resident #015 was reviewed including the RAI-MDS assessments, the care plan and the progress notes. The RAI-MDS documentation indicated the resident was identified as being at an identified risk for incontinence and at a specific level of incontinence according to the most recent assessment.

The progress notes were reviewed and indicated the registered staff on duty the previous day reported the resident's SDM had questioned why the resident was no longer using an identified incontinence product. It was noted that the product

used for the resident was changed by the staff.

The DOC confirmed the resident's SDM was not provided the opportunity to participate fully in the development and implementation of the resident's plan of care related to the change in incontinence product used. (123)

E) A representative of resident #015 reported to the inspector that on an identified date in June, 2018, while the PSW was getting the resident ready for bed, the resident had a change in status. The registered staff was notified and assessed the resident. The resident was assessed and no longer had a change in status. The nurse decided not to contact the SDM. The PSW informed the SDM. The SDM contacted the physician.

The clinical record of resident #015 was reviewed including the progress notes. The progress notes of on an identified date in June, 2018, indicated the PSW called the registered staff to the resident's room. The physician's note of on an identified date in June, 2018, indicated the doctor spoke to the resident's SDM who reported they were not informed of an incident that occurred the previous day. The physician was not notified of the incident until that night.

The DOC confirmed that the resident's SDM was not provided the opportunity to participate fully in the development and implementation of the plan of care related to the above incident. (123) [s. 6. (5)]

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

A) On on an identified date in July, 2018, resident #060 was was observed by the Inspector to be incontinent at an identified time. An observation of the resident was made an hour and a half later and the resident was observed to be incontinent. A review of the clinical record confirmed that resident #060 was to be checked prior to meals and after meals. An hour and a quarter later, the Inspector confirmed the resident remained incontinent. Interview with RPN #106 confirmed that the resident was to be checked prior to meals and after meals and confirmed resident #060 was incontinent. Interview with PSW #105 confirmed the resident was not toileted prior to or after their meal as it directed staff in the resident's plan of care.

The licensee failed to ensure that the care set out in the plan of care was provided

to resident #060 as specified in the plan. (506)

B) On on an identified date in July, 2018, resident #098 was incontinent and was noted to be demonstrating responsive behaviours and resistive to care. PSW #143 and #109 provided care and the resident sustained an injury. A review of the plan of care confirmed that when the resident was being resistive to care the resident was to be left alone and to re-approach at a later time. Interview with the Acting ED confirmed that the staff did not follow the plan of care for responsive behaviours and re-approach the resident when the resident was being resistive to care. The licensee failed to ensure that the care set out in the plan of care was provided to resident #098 as specified in the plan.

This area of non-compliance was identified in relation to CI inspection #018579-18. (506)

C) On on an identified date in August, 2018, the Inspector observed resident #098 for three hours. During this time, the resident was not checked for incontinence. A review of the plan of care under the PSWs' tasks confirmed that the resident was to be checked every two hours. Interview with PSW #109, confirmed that they last checked the resident at an identified time and were aware that the plan of care directed them to check every two hours and confirmed that the plan of care was not followed as the resident was not checked every two hours.

This area of non-compliance was identified in relation to Complaint inspection #006339-18. (506)

D) A complaint was received regarding improper care related to an identified treatment for resident #074 . The complaint outlined that on several occasions the resident's treatment had not been applied/administered properly or as ordered by the physician.

i) A review of the clinical record identified that the resident was to have an identified treatment administered as per the treatment administration record (TAR) ordered on on an identified date in November, 2016. The resident's care plan last revised on an identified date in July, 2018, identified that the resident was to have the treatment applied as per physician orders.

Progress notes from an identified date in January, 2018, were reviewed. Interview with registered staff #147 confirmed that on the identified date, the

treatment was not provided and the staff were not following the resident's plan of care.

ii) Resident observations completed on an identified date in August, 2018, identified that resident #074 did not have their treatment applied. This was immediately brought to the attention of registered staff #142. Registered staff #142 confirmed that the treatment was not in place and the staff were not following the resident's plan of care.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #074 as specified in the plan.

This area of non-compliance was identified in relation to Complaint inspection #012432-18. (674)

E) Critical Incident report #2779-000008, submitted to the MOHLTC on on an identified date in May, 2018, was reviewed. It was noted that on on an identified date in April, 2018, resident #004 reported to the DOC an allegation of abuse. A plan was initiated which included that all staff were to be made aware of the allegation and specified instructions were given regarding the alleged abuser. The former Administrator was to take specific action.

The resident's record including the progress notes were reviewed. It was noted on on an identified date in April, 2018, the former Administrator was to take specific action. On an identified date in April, 2018, the resident reported to the registered staff a concern regarding the alleged abuser. The staff spoke with the Administrator who verified that they had not taken the specific action as planned. The resident was notified that the action had not been completed and was given direction.

On on an identified date in May, 2018, it was noted the resident reported to registered staff that the prior evening a concern with the alleged abuser and that when staff were alerted to the concern no action was taken.

On on an identified date in May, 2018, it was noted the resident met with the Administrator and the SW about the incident. The resident reported the incident, the outcome and what they suspected may have happened.

The staff did not provide care as per the plan of care related to the incident.

The ADOC, Corporate staff #128 and #136 confirmed the home did not ensure the care set out in the plan of care was provided to the resident as specified in the plan. (123)

This area of non-compliance was identified in relation to CI inspection #009768-18. (123) [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that set out the planned care for the resident, to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, to ensure that the plan of care based is based on an assessment of the resident and the resident's needs and preferences, to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given the opportunity to participate fully in the development and implementation of the resident's plan of care and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long term care home to have, institute or otherwise put in place any policy or procedure, the policy or procedure was complied with.

In accordance with O. Reg 79/10, s. 30(1) the licensee was required to have an organized program for each of the interdisciplinary programs under section 48 of this regulation, which included a fall prevention and management program, and was required to have relevant policies, procedures and protocols for the program.

Specifically, staff did not comply with the licensee's policies:

"Fall Prevention Program – Head Injury Routine”, section 6. 2 dated June 2017, identified that a Head Injury Routine (HIR) would be initiated for all resident falls that were not witnessed and for witnessed resident falls that included the possibility of a head injury. If the resident was placed on HIR, registered staff were to observe and document in the Neurological Flow sheet in Point Click Care (PCC) computerized charting. The frequency of the HIR observation assessment would be every 15 minutes for the first hour, every hour for the next two hours and then every four hours for 24 hours. Interview with the ADOC and corporate RAI-MDS Consultant confirmed that the Head Injury Routine (HIR) was the same and was to be assessed for the same time frame as the neurological flow sheet documented in the progress notes.

Resident #084 was at an identified risk for falls:

i) On an identified date in July, 2018, the resident sustained an unwitnessed fall. A neurological flow sheet was not initiated.

ii) On an identified date in August, 2018, the resident sustained an unwitnessed fall. The resident sustained an injury. A neurological flow sheet assessment was completed at an identified time on that date, however, not completed again until an identified time the following morning. The neurological flow sheet was completed again at two identified times and then not again until on an identified date in August, 2018, at an identified time.

iii) On an identified date in August, 2018, the resident sustained an unwitnessed fall. One neurological flow sheet assessment was completed at an identified time on the same date.

iv) On an identified date in August, 2018, the resident sustained an unwitnessed fall. The neurological flow sheet assessment was completed at six identified times.

v) On an identified date in August, 2018, the resident sustained an unwitnessed fall. A neurological flow sheet assessment was completed at an identified time and then again twice the following day.

vi) On an identified date in September, 2018, the resident sustained an unwitnessed fall. A neurological flow sheet assessment was completed at two identified times and then not again until the following day at an identified time.

vii) On an identified date in September, 2018, the resident sustained an unwitnessed fall. A neurological flow sheet assessment was completed at three identified times and then the following day at an identified time and twice the day after that.

The neurological flow sheet assessment was not initiated or completed at the frequency indicated in the policy for the above falls sustained by resident #084 as confirmed with the ADOC. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long term care home to have, institute or otherwise put in place any policy or procedure, the policy or procedure was complied with.

A) In accordance with Ontario Regulation 79/10 section 114 (2) the licensee shall ensure that written policies and protocols are developed for the medication

management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, the staff did not comply with the licensee's policies:

"Individual Monitored Medication Record" policy 6-5 dated January 2018, included the following: “The Individual Monitored Medication Record is to be regularly audited for accuracy and any discrepancies investigated. 5. Sign on the Individual Monitored Medication Record each time a dose was administered. Include the date, time, amount given, amount wasted, and new quantity remaining.”

Critical Incident report #2779-000029-17, submitted to the MOHLTC on on an identified date in November, 2017, was reviewed. The CIS stated that during a shift change medication count, it was discovered that the count of a medication for resident #083 was incorrect.

Resident #083’s clinical record was reviewed. On on an identified date in November, 2016, the physician ordered an identified dose of a medication. On an identified date in November, 2016, an “Individual Monitored Medication Record” was started for resident #083 for an identified dose of a medication.

On an identified date in November, 2016, the first dose of the medication was administered to resident #083. The quantity remaining was documented. In August, 2018, the Inspector and registered staff #104 identified that this was a miscalculation. Registered staff #104 also acknowledged that the calculations were incorrect from the first dose administered. At the time of the inspection, registered staff #164 who had administered the first dose was unavailable for interview.

Over the time period from November, 2016, through to October, 2017, the medication was documented as administered a total of thirteen times. Dating back to the first dose given to resident #083, the actual quantity was not the same as the amount recorded on the “Individual Monitored Medication Record” for resident #083.

The review of the Individual Monitored Medication Record for resident #083, identified that a total of eight registered staff had administered this medication. Three registered staff were interviewed and were aware of how to correctly

perform medication calculations.

During interview with the Clinical Pharmacist staff #154, they stated that the registered staff should have completed the drug usage calculation by subtracting the amount used from amount it had started with.

During interview with the former DOC staff #129, it was reported that the unaccounted medication was likely lost through wastage, or registered staff did not sign that they administered it. They also confirmed that they were unable to determine exactly where the missing medication had gone. They reported that monthly medication audits were to be completed by the two registered staff, who at the time were the nurse unit managers.

During interview with registered staff #104, who was one of the nurse unit managers, they stated that they had never seen the audit form nor were they ever asked to complete the audit form that the Inspector showed them.

Corporate staff #128 was asked to locate any completed audits of the Shift Change Monitored Drug Count. Corporate staff #128 advised the Inspector that they were unable to locate any audits for the Individual Monitored Medication Records.

The home failed to ensure that the home's policy was complied with as the registered staff did not complete the required documentation, the registered staff signed on the Individual Monitored Medication Record each time a dose was administered, included the date, time, amount given, amount wasted, and new quantity remaining; that the Individual Monitored Medication Record were regularly audited for accuracy and any discrepancies investigated in order to have identified and prevented the ongoing miscalculation of the medication.

The licensee failed to ensure that where the Act or this Regulation required the licensee of a long term care home to have, institute or otherwise put in place any policy or procedure, the policy or procedure was complied with.

This area of non-compliance was identified in relation to CI inspection #021543-18. (536)

B) In accordance with Ontario Regulation 79/10 section 114(2) the licensee shall ensure that written policies and protocols are developed for the medication

management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee's policies:

"Shift Change Monitored Drug Count" policy 6-6, dated January 1, 2018, included the following items to be completed by registered nursing staff: 2. “Two staff (leaving and arriving), together: a) count the actual quantity of medications remaining; b) record the date, time, quantity of medication and sign in the appropriate spaces on the Shift Change Monitored Medication Count form and c) confirm actual quantity was the same as the amount recorded on the Individual Monitored Medication Record"

Critical Incident report #2779-000027-17 submitted to the MOHLTC on an identified date in October, 2017, involving two medications missing from their sealed packages for resident #082 and Critical Incident report #2779-000030-17 submitted to MOHLTC on an identified date in December, 2017, stating that resident #081 had two medications go missing.

The home was only able to provide three of five home areas of the completed sheets from this time frame for the Inspector. The “Shift Change Monitored Medication Count” completed from October, 2017 to January, 2018, was reviewed and included:

During the month of October 2017, there were 10 shifts that medication counts had only one signature 2300 hours-two counts done by one staff; 0700 hours-two counts done by one staff; 2030 hours-three counts done by one staff; 1500 hours-two counts done by one staff and 1300 hours-one count done by one staff.

During the month of November 2017, there were 9 shifts that medication counts had only one signature-2300 hours-two counts done by one staff; 0700 hours-three counts done by one staff; 2030 hours-one count done by one staff; 1500 hours-one count done by one staff and 1300 hours-two counts done by one staff.

During a review from identified dates in December, 2017 to January, 2018, there were 11 shifts that medication counts had only one signature-2300 hours-one count done by one staff; 0700 hours-four counts done by one staff; 1500 hours-five counts done by one staff and 1300 hours-one count done by one staff.

A review was also completed of a full month at the time of this inspection to identify if medication counts were still being completed by one registered staff. The following missing signatures were identified in July, 2018, on the Shift Change Monitored Medication Count. Please note the Inspector only viewed two out of five home areas of the completed sheets for the home:

During the month of July 2018, there were 9 shifts where medication counts had only one signature -2300 hours-one count done by one staff; 0700 hours-one count done by one staff; 2130 hours-two counts done by one staff; 1500 hours-four counts done by one staff and 1300 hours-one count done by one staff.

During interview with the Inspector, it was identified by registered staff #142 that there were a number of reasons why medication counts were done by one registered staff. Staff #142 stated that they did not have additional registered staff to complete the count with them and they had been directed by senior staff to do it themselves.

During interview with registered staff #104 following a review of a number of missing signatures on the medication count sheets, they stated that in April 2018, with all the cut backs, their shifts now ended at 1300 hours or 2030 hours and that the short shift registered staff would do the medication count as they were leaving. However, they did not always remember to sign and/or they did not have the full time eight hour nurse available to complete the count. Registered staff #155 stated that at 2300 hours there were two registered staff who had to do the medication count on five home areas when they arrived, which required a significant amount of time. Registered staff #155 stated, they did what they could however, one nurse could not visit all the home areas to complete the medication counts so, it was a problem and two signatures would not be completed. Both registered staff #104 and #155 confirmed that medication counts should be completed by two registered staff.

The home failed to ensure that the policy was complied with.

This area of non-compliance was identified in relation to CI inspection #021539-18 and #028494-17. (536)

C) "Readmission of Residents from Hospital" policy 7-5, dated February 2017, included the following items to be completed by registered staff: "Medication

reconciliation is completed by comparing readmission orders and hospital MAR to orders on previous MAR in the home and bringing any differences to the attention of the nurse, pharmacist and prescriber. Ensure MAR accurately reflects all new and changed orders".

A review of the home’s medication incidents for the second quarter was completed. This review included an Incident Report dated June, 2018, regarding a dosage transcription error that involved resident #061 receiving an incorrect dosage a medication.

An error occurred when the orders from the hospital were incorrectly copied onto the reconciliation form. The hospital transfer records indicated that a dose of medication be administered. The reconciliation form was sent to pharmacy prior to the second check being completed by a second registered staff and the resident was administered the incorrect dosage of the medication.

Interview with registered staff #123 identified that the error was found during the second check comparing the hospital orders, the reconciliation and the electronic Medication Administration Record (eMAR) together.

Interview with the RAI/MDS Coordinator #131 identified that based on their internal investigation, resident #071 received an incorrect dosage of the medicationl. Interview with RAI /MDS Coordinator #131 confirmed that the staff did not follow the licensee's policy in relation to accurate documentation of reconciliation based on hospital recommendations.

Staff did not comply with the policy as directed.

D) "The Medication Pass" policy 3-6, dated January 2018, included the following items to be completed by registered nursing staff: "Administer medications and ensure that they are taken".

i) A review of the home’s medication incidents for the second quarter was completed. This review included an Incident Report dated May, 2018, regarding an incident where a scheduled medication was not administered involving resident #071.

Upon review of the incident report, it was identified that the resident did not receive their scheduled dose of medication. It was later found in its dated and

timed package in the locked medication cart on a subsequent shift.
A review of the May 2018, eMAR identified that a signature was not in place on the identified date in May, 2018, as required to identify that the medicaiton was given.

Interview with the registered staff #123 identified that they found the medication in the medication cart at the end of their shift on an identified date in May, 2018. Registered staff #123 reported that they had filled out the incident reports and notified the physician of the incident. The resident did not have any adverse effects as a result and they confirmed that the resident received PRN medication along with increased monitoring after the incident.

Interview with the RAI/MDS Coordinator #131 identified that based on the home's internal investigation, resident #071, at the identified date and time, did not receive their medication as prescribed. They also confirmed that registered staff #126 did not follow the home's medication administration policy.

ii) A review of the home's medication incidents for the second quarter was completed. This review included an Incident Report dated May, 2018, regarding an incident of scheduled medication that was not administered involving resident #070. The resident #070 did not receive a scheduled dosage of two medications as prescribed by their physician. The medications were found in their dated and timed package in the medication cart on a subsequent shift.

A review of the progress notes identified that registered staff #116 found the medications, completed the required incident reports and assessed the resident as documented. The resident did not have any harm as a result.

Interview with the registered staff #116 confirmed the information as above. The resident received the next scheduled doses of the medications as ordered.

Interview with the RAI Coordinator #131 identified that based on their internal investigation, resident #070, at the identified date and time, did not receive their medication as prescribed.

Staff did not comply with the licensee's policy as directed. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation required the licensee of a long term care home to have, institute or otherwise put in place any policy or procedure, the policy or procedure is complied with, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents did not have access to were,

iii. equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation.

In September, 2018, four exit or stairwell doors were tested to determine if an audible alarm was located at each door.

Each of the four doors were equipped with an access control system (magnetic locks and a numeric key pad) and were interconnected to the resident-staff communication and response system. Each door was tested by unlocking the magnetic locks by entering a code on the key pad and holding the door open until the resident-staff communication and response system (RSCRS) sounded within the corridor [between 23-30 seconds]. The RSCRS was verified to have been silenced by entering the same code on the key pad after closing the door. However, none of the doors had a separate door alarm that sounded at the door. Staff #108 and #143, who were in an identified home area at the time of the test and noted that the sound that was activated for the doors was not any different from the sound that activated when a resident used the RSCRS. They both stated that it was difficult for them to know the difference and if no dome lights [visual component of the system] were activated above bedroom doors, they would be required to go to the nurse's station to look at the visual panel to determine which door was unlocked. However, when the nurse panel was checked for the home area, two fire exit doors were not labelled on the panel.

The licensee failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, and doors to which residents had access, were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation. [s. 9. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents did not have access to were, equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written hot weather related illness prevention and management plan met the needs of the residents and was developed in accordance with prevailing practices and implemented when required to address the adverse effects on residents related to heat.

Prevailing practices are generally accepted widespread practices which are used to make decisions. The MOHLTC developed a guidance document entitled "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care Homes, 2012", which was shared with all Long Term Care Homes in 2012. The guidance document includes information with respect to monitoring the internal building environment when outdoor conditions exceed a temperature of 25 degrees Celcius (C) and interventions to reduce heat related illness and to reduce heat in the building when the Humidex reaches 30 [some

discomfort will begin at this level]. The Humidex is an index number that is used to describe how the weather feels to the average person and is determined when the effect of heat and humidity are combined. This is to ensure that cooling systems or other cooling alternatives in the building are functional and able to provide relief to residents in certain designated areas should they require it. The guidance document also includes information with respect to enhanced resident symptom monitoring related to excessive heat.

Heat warnings were issued for the Province of Ontario, including Brant County, beginning on June 17, 2018, when the Humidex approached or exceeded 40. Values over a Humidex of 35 were experienced on June 17, 18, 29, 30, July 1-5, 15, 16, August 5, 6, 27-29, and September 1 to 4, 2018, at which time designated cooling areas, which include dining rooms and common spaces, must be available to residents if a home's central air conditioning system is not adequate, functional or has not been provided.

A complaint was received by the MOHLTC on an identified date in July, 2018, that a home area was uncomfortably hot and that the air conditioning system in the home did not appear to be functional. No residents with specific heat-related health effects were reported by the complainant other than the residents were uncomfortable and could not get any relief. The complainant identified that there was not much of a difference in air temperature between the dining rooms, sitting areas or the corridors. The Administrator was interviewed, and reported that the air conditioner failed as it could not keep up with the demand and was repaired on an identified date in July, 2018.

During the inspection, the acting Administrator who was the Vice President of Quality and Strategic Direction provided a policy entitled “Humidex Heat Response Plan – Heat Related Illness - H.5.01, dated April 2016, related to hot weather. The policy included direction that the Registered Nurse (RN) on duty would ensure that the Humidex and air temperature checks would be conducted and reported and would implement the Humidex heat and stress response plan. The policy included the requirement for the Humidex scale to be posted near air and temperature and humidity monitors and that staff on each day and evening shift would take and calculate the Humidex. Any reading over a Humidex of 34 would be reported to their manager. Appropriate interventions would be implemented by the DES, Administrator and Health and Safety Team. No procedures for maintenance staff, dietary services, activation or nursing staff were included and no specific available interventions were listed other than treatment

for various symptoms related to heat. The designated cooling areas were not listed in the policy and did not include how these areas would be kept cooler than the rest of the building when the Humidex reached 30 or greater, especially if cooling systems failed or were not designed to cool areas in extreme temperatures.

On identified dates in September, 2018, air temperature and humidity records were requested from the management of the home and various registered staff on duty. No records were produced and registered staff #140 reported that they were not aware of the policy. Numerous PSW's were interviewed on each of the five home areas who all reported that it was hot in the home during the heat warnings in each of the summer months, including the first week of September 2018. Maintenance records reviewed included submissions that it was “very hot and humid” and that the air conditioning was not working on identified dates in August, 2018. However, none of the PSW's could verify what the actual temperature in the various home areas was. PSW's reported that the air conditioners in some home areas froze and had to be shut down to thaw and that there was no air ventilation. A tour of the home was made and noted that the home was equipped with air and humidity gauges in corridors for three out of the five home areas. No gauges were in any dining room, activity room or lounge. No Humidex charts were posted near the gauges.

Confirmation was made with the Vice President of Environmental Resources that the air conditioning units in the home were maintained by an external company. The technician of the company was contacted and confirmed that the home was equipped with two different types of cooling units. The central core, between the front of the building and the back of the building, had two cooling units, both with stage two compressors. The five wings or home areas had 12 smaller compressors (with stage one compressors) within the duct work. The technician confirmed that the 12 smaller compressors were not able to efficiently cool the home areas when outdoor temperature and humidity levels were extreme and were only able to operate on one level of speed. The two-stage cooling system operated at two different speeds, and was able to adjust depending on the outdoor values and was able to dehumidify the air better. When relative humidity and temperatures rise, the two-stage compressor responds, immediately adjusting its output to the higher speed to keep up with demand. The technician confirmed that the smaller compressors had been allowed to run continuously causing the compressors to freeze. Service reports for June, July, August and September 2018, included repairs to multiple units for issues related to the

various units failing, either due to leaking refrigerant, thermostat programming issues and parts issues. Therefore, multiple areas of the home were without conditioned air for the duration of the disrepair and no verification could be made by the licensee that designated cooling areas were adequately cooled at all times when the outdoor Humidex or the Humidex for other areas of the building was over 30.

The licensee's hot weather related illness prevention and management plan was not developed in accordance with prevailing practices and implemented when required to address the adverse effects on residents related to heat. The plan provided by the licensee was not developed in accordance with the "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care Homes, 2012", related to the monitoring of the designated cooling areas with respect to the Humidex and what steps or actions needed to be taken if the existing cooling systems could not provide adequate cooling in the required designated spaces. [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 to ensure that the written hot weather related illness prevention and management plan met the needs of the residents and was developed in accordance with prevailing practices and implemented when required to address the adverse effects on residents related to heat, to be implemented voluntarily.

WN #14: 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. Without in any way restricting the generality of the duty provided for in section 19, the licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and to ensure that the policy was complied with.

The home's policy and procedure, "Abuse-Prevention, Elimination and Reporting" policy dated May 2017, was reviewed. It included: "All staff are required to report witnessed or suspected abuse."

The clinical record of resident #004 was reviewed including the progress notes and social worker record. The documentation indicated that on an identified date in April, 2018, the resident was involved in a verbal confrontation which included a threat of retaliation related to an alleged abuse incident they had reported. On an identified date in April, 2018, the resident was noted to be upset as an identified person made an abusive comment in relation to the same incident.

Registered staff #101 was interviewed and confirmed the incident met the home's policy definition of verbal abuse and they did not report the alleged verbal abuse incident as per the home's abuse policy and procedure. They indicated that at the time, they felt it was part of the alleged abuse incident that was already being dealt with by the home.

The progress note documentation indicated that on an identified date in May, 2018, resident #004 reported to the staff that the alleged abuser made an abusive comment. It was noted that the staff asked the resident what the resident wanted the staff to do and the resident stated nothing and the resident indicated they just wanted the staff to be aware.

Registered staff #116 was interviewed, confirmed and reported the alleged abuse incident was written on the 24-hour report and submitted to the former

Administrator. The information was documented by exception on the 24-hour report. The staff reported that the management were to have read all the 24-hour reports submitted to them.

The DOC confirmed the above alleged incidents met the home's abuse policy definition of verbal abuse and were required to have been reported as per the home's abuse policy and procedure and that there was no record or evidence available that the above incidents were reported.

The home did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. [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 to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and to ensure that the policy is complied with, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Ontario Regulation 79/10 s. 5 describes neglect as:
the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Critical Incident report #2779-000020-18 submitted to the MOHLTC alleging improper and/or incompetent treatment of a resident that resulted in harm or risk to a resident was reviewed. On an identified date in August, 2018, an incident had occurred of potential staff to resident neglect and/or abuse towards resident #041. Resident #041 required the use of a level of assistance for transfers. On an identified date in August, 2018, the resident required personal care and registered staff #101 assisted PSW #110 to facilitate the provision of care. The resident sustained a fall which resulted in injury.

Interview with PSW #110, confirmed the staff did not use safe transferring and positioning devices or techniques when they failed to provide the level of assistance when providing care to the resident. The DOC confirmed that an investigation was not competed at the time as not all parties involved were interviewed and the home did not have any documentation of an investigation related to the alleged incident of abuse and/or neglect that occurred on the identified date in August, 2018.

This area of non-compliance was identified in relation to CI inspection #020604-18. [s. 23. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: iii) anything else provided for in the regulations; (b) appropriate action is taken in response to every such incident; and (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that any of the following occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee

or staff that resulted in harm or risk of harm.

Ontario Regulation 79/10, 2007 s. 2 describes sexual abuse as:
(b) any non-consensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Critical Incident report #2779-000008-18 was reviewed and it was noted that on an identified date in April, 2018, resident #004 was allegedly sexually assaulted. The CI report was submitted to the Director on an identified date in May, 2018. The resident's record was reviewed including the progress notes and it was noted that on an identified date in April, 2018, the resident informed the former DOC that on an identified date in April, 2018, an identified person made an abusive gesture toward the resident. The progress note indicated the former DOC informed the resident they would inform the former Administrator the following day.

The ADOC was interviewed and reported they spoke with the resident about the incident and reported the incident to the former DOC and former Administrator who indicated they would address the issue. The former DOC and Administrator reported the allegation of sexual abuse three weeks after first receiving information about the allegation and investigated all incidents to the MOHLTC.

The DOC and Corporate staff #128 confirmed the home did not immediately report the suspected sexual abuse to the Director.

This area of non-compliance was identified in relation to CI inspection #009768-18. [s. 24. (1)]

2. The licensee failed to ensure that when a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident resulted in harm or risk of harm to the resident shall immediately report this suspicion to the Director.

Critical Incident report #2779-000013-18 submitted to the MOHLTC on an identified date in July, 2018, alleging abuse toward resident #098 took place was reviewed. The home's investigative notes identified that the ADOC was made aware of the allegation of abuse on an identified date in July, 2018, from communication from the family. The ADOC confirmed that they did not complete a CI but forwarded this on to the former Administrator. In an interview with the

Acting Administrator and consultant Administrator, it was confirmed the licensee did not immediately report the allegation of abuse to the MOHLTC Director.

This area of non-compliance was identified in relation to CI inspection #018579-18. [s. 24. (1)]

3. The licensee failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm.

Critical incident report #2779-000019-18 submitted to the MOHLTC on an identified date in August, 2018, was reviewed. It was noted that on an identified date in August, 2018, the DOC noticed residents #053, #054, #055, #056, #057 and #075 were missing from the meal service. The DOC questioned PSW #111 who reported that due to staff shortages they were not able to get all residents to the dining room. The residents were in bed because they did not have time to provide care to them. Also, between meal beverages and after meal snacks were not being provided to the residents as the staff had been exempted from distributing the snack cart for 12 weeks.

The DOC was interviewed and reported that the staff informed them that the number of staffing hours had been reduced and that resulted in the staff not getting the residents to the dining area or providing the residents' beverages and snacks.

Corporate staff #128, the DOC and the ADOC reported information as contained in the CI report. Corporate staff #128 and the DOC reported the MOHLTC after-hours pager was not contacted about the incident and confirmed the incident was not immediately reported to the Director as noted on the CI.

This area of non-compliance was identified in relation to CI inspection #020603-18. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who has reasonable grounds to suspect that any of the following occurred or may have occurred, immediately report the suspicion and the information upon which it was based to the Director.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that results in harm or risk of harm, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the care plan sets out clear directions to staff and others who provided direct care to the resident.

The document known as the care plan was not completed fully for resident #041 for almost two weeks.
The initial admission assessment plan of care completed the same day indicated under transfers: a specific level of assistance.
The Comprehensive Admission Assessment also dated the same date under

section G1. Physical functioning and structural problems: transfers indicated a different level of ability. Transfer/lift information indicated another level of assistance and direction.
The physiotherapy initial assessment under transfers indicated a level of assistance.
The current care plan on an identified date in August, 2018 under transfers indicated a level of assistance.
The SALT (Safety Assessment Lift and Transfers) assessment dated July, 2018 indicated different direction regarding the time of day for the assistance required.
The SALT cards posted on the wardrobe in the resident's room were not consistent with the SALT assessment.
On an identified date in August, 2018, the ADOC confirmed that the care plan did not set out clear directions to staff and others who provide direct care to the resident.

This area of non-compliance was identified in relation to CI inspection #020604-18. [s. 24. (3) (b)]

2. The licensee failed to ensure that the resident was reassessed and the care plan was reviewed and revised when the resident's care needs changed.

A falls risk assessment was completed for resident #041 on an identified date in July, 2018, and the resident was deemed to be at an identified risk for falls, however, the written plan of care for the resident did not set out the planned care for the resident in relation to falls prevention. The resident sustained a fall with injury on an identified date in August, 2018, and a falls risk assessment was completed. The resident was then deemed to be at another risk for falls, however, the written plan of care for the resident was not updated to set out the planned care for the resident in relation to falls prevention. The plan of care did not include any goals or falls prevention interventions as confirmed with the DOC. The care plan was not reviewed and revised when the resident's care needs had changed. (156)

This area of non-compliance was identified in relation to CI inspection #020604-18. [s. 24. (9) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care plan sets out clear directions to staff and others who provide direct care to the resident and to ensure that the resident is reassessed and the care plan is reviewed and revised when the resident’s care needs change, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk.

On an identified date in September, 2018, resident #084 was observed to have a restraint in place. Review of the plan of care did not identify that they required the restraint. A review of the resident's clinical record did not include an assessment for the use of the restraint that included any information on alternatives that had been considered or tried. Interview with the ADOC, confirmed that the restraint had not been assessed and the ADOC confirmed that the plan of care did not include alternatives that had been considered and tried for the restraint. [s. 31. (2) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that alternatives to the use of a personal assistance services device (PASD) under subsection (3) had been considered, and tried where appropriate, but would not be, or had not been, effective to assist the resident with the routine activity of living.

A) On an identified date in July, 2018, resident #003 was observed to have PASD's in place. Review of the plan of care identified they required the PASD's. A review of the resident's clinical record did not include an assessment for the use of the PASDs that included any information on alternatives that had been considered or tried.

Interview with RPN #116 reported that alternatives to the use of the PASD's had not been considered and tried.

B) Resident #001 was observed. Review of the plan of care identified they required the PASD. A review of the resident's clinical record did not include an assessment for the use of the PASD that included any information on alternatives that had been considered or tried.

Registered staff #116 reported that resident #001 was using the PASD. Registered staff #116 also indicated they were unsure if the assessment form had been completed regarding alternatives and how they made the decision to use the PASD. Registered staff #116 completed a review of the resident's clinical record and confirmed this was not done.

Registered staff #116 confirmed that alternatives to the use of the PASD had not been considered and tried for resident #001. (123) [s. 33. (4) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that alternatives to the use of a personal assistance services device (PASD) under subsection (3) have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

A) Resident #040 was observed not to be dressed appropriately for the time of day on an identified date in July, 2018 by inspectors #156 and #506 at two separate times of day. A review of the plan of care for this resident indicated specific instruction for staff in relation to dressing. PSW staff #111 and #117 confirmed that the resident was not dressed in his or her own clean clothing and appropriate clean footwear.

B) During the inspection, a family member of resident #015 reported to the Inspector that the resident was not dressed appropriately for the time of day.

On an identified date in August, 2018, resident #015 was observed not dressed appropriately for the time of day. PSW #138 reported the resident was not dressed. The DOC observed resident #015 and confirmed the resident was not assisted in getting dressed as required.

The resident was not assisted with getting dressed as required, and was not dressed appropriately, suitable to the time of day and in keeping with their preferences, in his or her own clean clothing and appropriate footwear. (123) [s. 40.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The licensee failed to ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, (a) had successfully completed a personal support worker program that met the requirements in subsection (2); and (b) had provided the licensee with proof of graduation issued by the education provider.

On an identified date in July 2018, a specified staff member was observed to be wearing ‘scrubs’. When questioned by the inspectors (#506, #123 and #156) as to why they were wearing scrubs, they responded that “they were acting as a PSW today”. PSW #110 and #109 confirmed that the specified staff member did this approximately once per month since they started which was also confirmed by the Administrator. Interview with the Administrator as well as registered staff #107 confirmed that the duties performed included dressing (putting socks on); portering; feeding; lifts and transfers. The specified staff member confirmed that they had not met the requirements of a personal support worker. [s. 47. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, (a) had successfully completed a personal support worker program that meets the requirements in subsection (2); and (b) had provided the licensee with proof of graduation issued by the education provider, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident has fallen, the resident had been assessed and a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #041 sustained a witnessed fall on an identified date in August, 2018, while RPN #101 and PSW #110 were performing care. As a result, the resident sustained an injury. As confirmed with the DOC, a post-fall assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

This area of non-compliance was identified in relation to CI inspection #020604-18. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident had fallen, the resident had been assessed and a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who requires continence care products have sufficient changes to remain clean, dry and comfortable.

A) On an identified date in August, 2018 resident #015 was observed and an odour of incontinence was noted. The DOC was informed of the observation and checked the resident immediately. They reported the resident was incontinent. They were not toileted for incontinence. The DOC confirmed that resident #015 used continence care products and did not have sufficient changes to remain clean, dry and comfortable. (123)

B) On an identified date in July, 2018, resident #060 was observed with signs of incontinence. The resident was observed again an hour and a half later where it was noted the resident still had signs of incontinence. A review of the clinical record related to continence care confirmed that the staff were to check resident #060 for and toilet the resident if required prior to meals and after meals. Seventy-five minutes later, the resident was again observed and it was noted that the resident still exhibited signs of incontinence. Interview with RPN #106, confirmed that the resident was to be checked prior to meals and after meals and confirmed resident #060 had been incontinent. PSW #105 confirmed resident #060 was not checked or toileted prior to or after their meal and therefore, did not have sufficient changes to remain clean, dry and comfortable. (506) [s. 51. (2) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who required continence care products had sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written record relating to each evaluation that included: date of the evaluation; names of the persons who participated; summary of the changes made, and the date that those changes were implemented.

The home was requested to provide the written record of the home's annual evaluation of the responsive behaviour program. The home provided a Quality Management Audit Report Behaviour/Responsive Behaviour Management Audit and Evaluation, dated February 23, 2018. The document was reviewed and it did not include the names of the persons who participated; a summary of the changes made and the date those changes were implemented.

Corporate staff #130 reported the home changed their process of completing the annual evaluations and the written record is not available at this time. They confirmed the written record related to the evaluation did not include names of the persons who participated; the summary of the changes made and the date that those changes were implemented. [s. 53. (3) (c)]

2. The licensee failed to ensure that residents demonstrating responsive behaviours actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Resident #098 had a history of responsive behaviours. A care plan was in place with interventions to prevent these responsive behaviours. A review of the clinical record from June to August 2018, identified that these behaviours were being documented more frequently. On an identified date in July, 2018, the resident sustained an injury while care was being provided. A review of the clinical record when the resident was displaying responsive behaviours did not include any assessments, reassessments, monitoring and/or follow-up of the resident when they were demonstrating responsive behaviours. An interview with the ADOC, confirmed that the documentation did not include actions taken to prevent the responsive behaviours.

This area of non-compliance was identified in relation to CI inspection #018579-18. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there was a written record relating to each evaluation that included: date of the evaluation; names of the persons who participated; summary of the changes made, and the date that those changes were implemented, to be implemented voluntarily.

WN #25: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

It was confirmed during interview with the Administrator that the licensee failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations. It was noted that the home responded the following month at the next meeting as per the minutes; however, not within ten days. [s. 60. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

s. 72. (4) The licensee shall maintain, and keep for at least one year, a record of,
(c) menu substitutions. O. Reg. 79/10, s. 72 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system in the home at a minimum, provided, production sheets for all menus.

Interview with resident #072 identified concerns with the serving rotation. The resident also reported that they had complained that they often didn't get a choice at meal time as the home ran out food.

An observation of the dinner service was completed on an identified date in July, 2018. Resident #072 was observed to be served in a specified order in the rotation but was offered two choices. During the service the Dietary Aide #146 ran out of minced barbeque (BBQ) chicken wings before all residents were served who made that choice. More minced BBQ chicken was obtained from another unit.

One week of production sheets were requested. The productions sheets from identified dates in July, 2018, were reviewed. It was identified the production sheets did not indicate the menu items served each day, the number of portions prepared or the left overs or shortages at each meal.

In an interview with the Director of Culinary Services, it was identified that the home was not currently tracking food leftovers and shortages and this information was not being used when forecasting the number of portions of each food item to be prepared and sent to each dining room. It was identified that there had been some shortages of meal items but the items and frequency could not be confirmed as the documentation was not completed on the production sheets.

It was confirmed that the licensee failed to ensure that there were production sheets for the menu from the identified date in July, 2018. (583)

This area of non-compliance was identified in relation to Complaint #018920-18.
[s. 72. (2) (c)]

2. The licensee failed to ensure that the food production system, at a minimum, provided preparation of all menu items according to the planned menu.

Registered staff #142 reported that residents shared concerns that the food was not served as per the planned menu. On an identified date in July, 2018, it was identified that the BBQ pork ribs were severed without sauce at the dinner meal.

An observation was completed with the Director of Culinary Services (DCS) and it was noted there was extra stock of BBQ sauce. The recipe was reviewed with the DCS and it was confirmed that the BBQ sauce was to be added to the ribs.

An interview was completed with Cook #146 with the DCS and it was confirmed that the BBQ sauce was not added to the ribs according to the planned menu. [s. 72. (2) (d)]

3. The licensee failed to ensure that as part of the food production system, menu substitutions were documented on the production sheets.

An observation of the dinner service was completed on an identified date in July, 2018. It was noted that residents were served baked potatoes instead of the planned menu item of sweet potatoes.

A copy of the production sheet was requested and it noted that there was no documentation on the production sheet of the menu substitution. It was confirmed by the Director of Culinary Services that the menu substitution was not documented on the production sheet. [s. 72. (2) (g)]

4. The licensee failed to ensure that a record was maintained and kept for one year of menu substitutions.

Resident #072 complained that they often didn’t get a choice at meal time as the home ran out of food.

Records of the documented menu substitutions prior to July 2018 were requested . A review of the production sheets titled “APANS Production Cooks Log” had a substitution log section, and stated “any substitutions must be documented below”. No menu substitutions were found to be documented. An interview was completed with cook #148 and it was reported that prior to June, 2018, the cooks regularly substituted menu items (approximately five times per week) related to food items for the planned menu not being available.

In an interview with the Director of Culinary Services it was confirmed that a one year record of the menu substitutions were not maintained.

This area of non-compliance was identified in relation to Complaints #018920-18 and #020277-18. [s. 72. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the food production system in the home at a minimum, provided, production sheets for all menus, to be implemented voluntarily.

WN #27: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 73. Staff qualifications
Every licensee of a long-term care home shall ensure that all the staff of the home, including the persons mentioned in sections 70 to 72,
(a) have the proper skills and qualifications to perform their duties; and
(b) possess the qualifications provided for in the regulations. 2007, c. 8, s. 73..

Findings/Faits saillants :

1. The licensee did not ensure that all the staff of the home had the proper skills and qualifications to perform their duties.

An anonymous complaint was received on an identified date in June, 2018, that alleged that accommodation services (housekeeping/laundry) staff were being required by management staff to assist residents with meals and to assist personal support workers (PSWs) while they transferred residents using lift equipment without having proper qualifications to perform the duties. An identified staff member indicated that they did not receive any "hands on" formal or practical training upon hiring with the appropriate use of lift and transfer equipment or with respect to the residents' particular dietary risk issues such as choking. The identified staff member was not aware that their job duties required them to perform such tasks and provided a copy of the job description they had access to for a housekeeping aide dated January 2013. The job description did not include providing assistance with resident care. A current housekeeping aide job description was requested for review which was dated March 2018, and it included a job description that the aides were to "assist with safe lifts and

transfers once training had been completed" and "assist residents with meals including feeding, set up and clean up".

The identified staff member stated that the training only included a video tutorial, which summarized the expectations of both types of duties. The complainant felt that the tutorial was inadequate to perform the duties safely. The complainant stated that they felt continuous pressure from the former Administrator during the months of April, May and June 2018, to assist residents with meals without adequate training.

Accommodation services staff #177, #178 and #179, confirmed that they were aware of and occasionally took part in duties requiring them to assist PSWs with the process of using mechanical equipment to lift and transfer a resident and to assist residents with meals. Staff #177 attended formal training for both duties, which included hands on practice in 2017. According to the Vice President of Quality and Strategic Direction, each staff member had to attend a mandatory formal annual training course for various program services, including lifts and transfers and meal assistance, whereby a certificate of completion was awarded. Staff #178 and #179 and an identified staff member all started after the last formal session, and follow up training for new staff did not occur.

The licensee therefore did not ensure that all the staff of the home had the proper skills and qualifications to perform their duties. [s. 73.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all the staff of the home have the proper skills and qualifications to perform their duties, to be implemented voluntarily.

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee failed to ensure that procedures were developed and implemented for cleaning of the home, specifically tub rooms and soiled utility rooms.

According to the licensee's housekeeping policy entitled "Housekeeping – Daily Housekeeping Duties" (1.4) dated August 2018, for tub rooms, the policy failed to include all of the surfaces, fixtures and equipment located in the tub room that required cleaning and disinfecting. The policy included shower stalls, walls and curtains (for condition only). The floor cleaning routine was identified under the

"common spaces" section of the policy and under policy 1.6 related to cleaning floors. The frequency of cleaning the floors was daily, using a wet mop for two months, followed by a more robust cleaning process using a brush.

The policy included the soiled utility room cleaning procedures under the "common spaces" section and included a daily cleaning requirement for hoppers, sinks and floors. According to housekeeping schedules that were posted in housekeeping closets in each home area, utility rooms were also listed to be cleaned daily.

During the inspection between identified date in September, 2018, the soiled utility rooms in all five home areas were observed to have dirty floors, dirty sinks, walls and hoppers. The tub rooms, especially in two identified home areas, had an accumulation of debris and scale under and around the tub, dusty window sills, dusty exhaust grilles and dusty window toppers. All of the tubs had a build- up of scale on the tub surfaces. A note was posted on the wall in the identified home area tub room that the tub was to be descaled using a specific product on a weekly basis. The task was not assigned to a specific person.

The licensee therefore did not develop and/or implement procedures for cleaning of the home, specifically tub rooms and soiled utility rooms. [s. 87. (2) (a)]

2. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee ensured that procedures were implemented for cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs, and
(iii) contact surfaces

"Cleaning and Disinfecting: B. Equipment Cleaning, Disinfection, Sterilization", Policy dated November 2014, was developed to include direction for PSWs to use disinfectant on the inside of the tub and all surfaces of the shower chair/bath equipment as recommended by the manufacturer. An additional procedure was developed entitled "Rhapsody P200 Tub" and was posted on a wall inside of a tub room in an identified home area. The procedure stated that the "dispensing unit

on the tub" was to be used to disinfect the tub. The manufacturer's manual for the Rhapsody P200 tub also included the requirement for the user to place their disinfectant container, containing concentrated disinfectant, into the storage container area at the head of the tub and insert the hose line into the disinfectant container. The user was to ensure that the disinfectant was flowing correctly by checking the flow-meter located inside the storage area.

The inspector observed all seven tubs in the home. Each tub was determined to be in use by staff. According to PSWs who worked in each of the five home areas, the majority of the residents received a tub bath. Each tub was checked and noted to be missing the disinfectant from the storage area inside the tub. A container of the concentrated disinfectant was however seen in each tub room, located either on the floor next to the tub or on a surface next to the tub. On an identified date in September, 2018, in a home area tub room, staff #167 was observed pouring the concentrated disinfectant into the tub and used a brush to spread it around the surface of the tub. The staff member stated that the dispensing unit was not working. Staff #108 and #143 in a home area, when asked why the disinfectant was not in either of the two tubs, reported that the dispensers did not work and they dispensed the concentrated disinfectant manually. Discussion was held with the three staff members that the product was highly corrosive and could cause severe skin and eye injury when handled manually and that the sealant on the tub liner could be eroded.

Verification was made on an identified date in September, 2018, by a technician from the tub manufacturer, who was in the home to inspect each tub the day before, that the dispensing system was fully functional on both tubs in a home area as well as the other home areas with the exception of an identified home area. The tub dispenser in the home area malfunctioned and a part was ordered. Three out of the seven tubs had cracked disinfectant shower handles, but were still capable of dispensing the disinfectant.

The DOC and designated infection control person (staff #131), when interviewed did not conduct any audits of the tub rooms or evaluated the cleaning and disinfecting practices of the staff or were aware of any concerns related to staff practice around cleaning and disinfection of bathing equipment.

Prevailing practices for the use of a low level disinfectant on contact surfaces are found in a document entitled "Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings", April 2018,

developed by the Provincial Infectious Diseases Advisory Committee under Public Health Ontario. The document identifies the differences between "hotel cleaning" and "health care cleaning" practices and when to use disinfectant. Hotel cleaning is conducted in non-resident care areas such as lobbies, offices, corridors and service areas with the goal to remove dirt and dust and ensure a visually clean environment. Health care cleaning is conducted in resident care areas, which includes resident rooms and the approach aims to reduce or eliminate microbial contamination within the environment and should result in the elimination of, or a significant reduction in, microbial contamination of all surfaces and items within the environment, in addition to providing a visually clean environment. This requires, in addition to the performance of a hotel clean, an increased frequency and thoroughness of cleaning, as well as the use of disinfectants.

"Housekeeping – Daily Housekeeping Duties" (1.4) policy dated August 2018, were not developed in accordance with the above prevailing practice. The policy did not specify what areas required a "hotel clean" and which areas required a "health care clean". Procedures were limited and did not include cleaning resident bedrooms, especially high touch surfaces such as light switches, bed rails, telephones, nurse call pulls, door hardware, edges of furnishings, chair arms and any other high touch surface. The policy included changing out the garbage, dust mopping, toilet area, tub rooms, common areas, elevator, staff room and hair salon. The use of a "germicide" was mentioned on garbage receptacles, toilet bowls, hand rails, taps (in washroom and tub rooms). The policy did not include any information about deep cleaning routines or how many rooms were to be deep cleaned on a daily or weekly basis.

The MOLHTC received a complaint in 2018, that housekeeping staff were not disinfecting high touch surfaces in the home on a daily basis. Interviews with four different housekeepers identified that high touch surfaces did not get disinfected if they were assigned a short shift (four hours) or if they were pulled to perform other duties associated with resident services. The housekeepers reported that certain shifts were reduced from eight to four hours in the Spring of 2018, and stated that if working a short shift, there was no time to disinfect all high touch point surfaces.

A review of the housekeepers check list for the months of July, August and September 2018, which was completed daily by each housekeeper, included four columns labelled, toilet, sink/counter, floor and dusting. The "dusting" column was not checked off for the majority of the daily cleaning. According to staff #178 and

#179, if rooms did not appear dirty on the surface, the surface would not be cleaned (i.e. furniture, door knobs, light switches, floors) on a daily basis. Only four rooms per day received a more thorough cleaning, including high touch surface disinfection.

The licensee did not ensure that procedures were implemented for cleaning and disinfection of resident care equipment (tubs, tub lift chairs) or contact surfaces in accordance with manufacturer's specifications or prevailing practices. [s. 87. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures were developed and implemented for cleaning of the home, specifically tub rooms and soiled utility rooms and to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee ensured that procedures were implemented for cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs, and contact surfaces, to be implemented voluntarily.

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).**

Findings/Faits saillants :

1. As part of the organized program of laundry services under clause 15 (1) (b) of the Act, the licensee failed to ensure that procedures were implemented to ensure that a sufficient supply of clean linen, face cloths and bath towels were always available in the home for use by residents.

“Laundry – Linen Supply Control" policy 2.13 dated August 2018, was developed to ensure that an adequate supply of linens would be available for resident use. The procedure included that a “linen supplies list” [not included in the policy] would be posted in the laundry room for laundry aides to write down what was discarded and the Director of Environmental Services (DES), each month, would order the necessary linen and replace the discarded stock. The added stock was to be documented on an “inventory form” [not included in the policy] and disseminated either by the Director of Clinical Services or the DES.

The DES, was not available after an identified date in September, 2018, for interview to confirm how the laundry program was operated. According to a laundry aide #172 no “linen supplies list” was posted and discarded linen was not documented and that linens were discarded mostly by PSW's. Staff #172 reported that face cloths, peri care cloths and towels were not counted when removed from the dyer and placed into the clean care baskets on laundry carts before being delivered to each home area twice per day. No inventory was allocated to any particular home area. Not conducting an inventory for each home area or knowing what was being placed into circulation was also confirmed by staff #131 and the RAI/MDS Coordinator. Staff #172 confirmed that no additional or back up washed linen was stored in the laundry room and that linen was only washed when returned from the various home areas. A tour of the storage room with the VP of Environmental Services revealed approximately 30 dozen peri care cloths that were ordered on an identified date in September, 2018. Other supplies included over 10 dozen face cloths and hand towels.

Discussions with multiple PSW's between identified date in September, 2018, included that when one home area had a shortage of particular linen, staff sought linens in other home areas. Staff #175 and #174 who worked on the night shift reported that they or other staff routinely had to launder in order to have enough linen for resident care. Observations were made of linen carts on each home area. Although it appeared that adequate linen was available for use in the mornings, the identified home area clean linen cart was completely empty by 3 p.m. on an identified date in September, 2018. A staff member was seen distributing the linens with less than five face cloths on the cart and had not yet provided linens to all residents. The staff member stated that they did not have adequate face cloths on their cart and stated that they would need to go and search for some in another home area.

Written correspondence between staff and the Administrator and the DES on identified date in June, 2018 and August, 2018, was reviewed and identified shortages of linens for resident care. Orders were placed or stock was put into circulation only after the complaints were received. Staff #131 was interviewed and reported that they became aware of shortages only after staff complaints or from daily reports submitted by registered staff.

The licensee failed to ensure that their policy and procedures entitled "Laundry – Linen Supply Control - 2.13", was implemented to ensure that a sufficient supply of clean linen, face cloths and bath towels were always available in the home for use by residents. [s. 89. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures were implemented to ensure that a sufficient supply of clean linen, face cloths and bath towels were always available in the home for use by residents, to be implemented voluntarily.

WN #30: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

"General Equipment Maintenance" policy 3.4, dated August 2018, included that plumbing fixtures such as water faucets and aerators would be inspected on a

monthly basis, but did not include hoppers, toilets, tubs, sinks, showers, grab bars or washroom accessories such as toilet paper holders and soap and paper towel dispensers. It required that maintenance staff submit a completed preventive maintenance checklist to the Administrator monthly without any other direction as to the appropriate time frames for follow up action, how the plumbing fixtures would be maintained and by whom.

During the inspection, rusted toilet paper holders, rust stains in toilet bowls and/or rusted sink drains were observed in but not limited to identified resident rooms. No special cleaning requirements were listed in the housekeeping or maintenance policies and procedures to address these issues. Audits conducted by housekeeping staff were documented on a form entitled "Environmental Room Audit". The form included "stained toilets" but no maintenance related issues such as corroded, cracked or unmaintained fixtures or accessories. No records of completed audits could be found by the Vice President of Environmental Resources for the rooms identified above.

A sink was missing from the clean utility room in a home area during the inspection. Staff completed a written electronic report that the sink was leaking on an identified date in August 2018. No follow-up action was documented.

A hopper in a home area soiled utility room could not be flushed on an identified date in September 2018. According to staff in that home area, a screw driver needed to be used to flush the water. Personal support workers (PSWs) completed a written maintenance electronic report that the flush handle was broken on an identified date in July 2018. No response was documented. Another report was submitted on an identified date in August 2018, with a note that a screw driver was being used. No response was included. A third report was submitted on an identified date in September 2018 and the response included that parts were on order and that staff were instructed to use the screw driver to flush the water.

A shower head in a home area shower room was tested during the inspection and was not functional. Water squirted out from the shower arm mount for the hand shower head but not the shower head. The DES was present and was unaware of the issue. The DES suspected that there was scale build-up in the shower head preventing proper water flow. The PSW's in the home area on the day shift were aware of the issue and stated it had not worked for years. No maintenance request submissions could be found in the home’s maintenance request software

system.

Resident washroom sinks and hand sinks in activity rooms, soiled and clean utility rooms, nursing offices, dining rooms, an identified care room and tub rooms were covered in scale in and around the faucets and faucet aerators. Water pressure was limited in the identified care room. A trend was identified of maintenance requests related to leaking tubs, toilets, sinks and pressure issues between January and September 2018. As the DES was not available, confirmation could not be made as to whether their policy 3.4 was implemented to inspect and replace the aerators, clean the excessive scale and monitor sinks and toilets for leaks. Although the home had a water softening system, verification could not be made as to whether the water softening system was adequately functional, or whether it supplied softened water to only certain areas of the home.

A bathing tub located in a home area was observed to have silicone caulking on the bottom of the surface of the tub interior. PSW's reported that they could not clean the bottom surface because the brush they used got stuck in the silicone. The DES was informed immediately about infection control concerns. On an identified date in September 2018, a technician from the tub manufacturer arrived and reported that the tub shell was cracked and silicone had been applied to try and seal the cracks, which was not appropriate. A new shell or lining was required. The tub was taken out of service. The tub was last fully inspected by the tub manufacturer in September 2017, at which time the tub was identified to be in good operating order. A review of the licensee's preventive maintenance check list for February 2018, provided by the Vice President of Environmental Resources (VPER), did not include the condition of the tubs as a task to be performed by in house maintenance staff.

The licensee therefore did not ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks. [s. 90. (2) (d)]

2. The licensee failed to ensure that procedures were developed and implemented to ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents did not exceed 49 degrees Celsius (C), and was controlled by a device, inaccessible to residents, that regulated the temperature.

"Maintenance – Water Temperature" policy 3.12 dated August 2018, was not developed in accordance with section 90 (2) (g) of Ontario Regulation 79/10. The policy included a requirement to ensure that the water temperature remained below 49C but did not include how that would be achieved or what follow up actions (immediate and short term) would be necessary to reduce the water temperature or to ensure resident safety. No information was included regarding whether the hot water system was equipped with a device to regulate the water temperature.

The hot water supplied to areas of the home to which residents had access, such as showers and hand sinks in dining rooms, activity rooms, family laundry room and washrooms, was not controlled by a device that regulated the temperature. A tour of the mechanical room was conducted with the VPER. A mixing valve could not be located on any of the hot water lines in the room. On an identified date in April 2018, according to hot water records kept by registered staff, the water temperature at a hand sink in an identified room was 50.5C. Registered staff documented the exceeded temperature, but did not document what other action they took. According to electronic maintenance records, a maintenance person responded to this concern two days later, by stating that a quote was requested for a mixing valve. No further records could be provided that a mixing valve was ordered or installed. The VPER confirmed that no mixing valve was installed. [s. 90. (2) (g)]

3. The licensee failed to ensure that procedures were developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius (C).

"Maintenance – Water Temperature" policy 3.12, dated August 2018, was not developed in accordance with section 90(2)(i) of Ontario Regulation 79/10. The policy did not include any reference to monitoring the hot water temperature serving bathtubs or showers used by residents or how the temperature would be taken.

On an identified date in September 2018, the inspector randomly tested hot water temperatures using a probe stem thermometer [designed for liquids] in tub rooms and shower areas. The hot water temperature for the tub in a home area [which was equipped with built-in digital thermometer] was 38-39C and the tub in another home area was 35C, despite raising the digital thermostat to the maximum setting

on the control panel to 40C and letting the water run for four minutes. According to the manufacturer's instruction manual for the tubs in the home, a built-in thermostatic mixing valve controlled the water temperature and a maximum set point could be adjusted by a technician. The hot water temperature records provided by registered staff for the month of September 2018, did not include temperatures taken at any of the seven tubs or five showers in the home. The registered staff also confirmed that a infrared laser thermometer was used to measure the water temperature at resident accessible hand sinks, which is not an accurate instrument for measuring the temperature of liquids. [s. 90. (2) (i)]

4. The licensee failed to ensure that procedures were developed and implemented to ensure that if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents had access to hot water.

During the inspection, confirmation was made that the hot water temperature was not monitored by a computerized system, but was taken manually by staff. On an identified date in September 2018, hot water records were requested from registered staff in each of the five home areas. All were obtained with the exception of an identified home area, which the registered staff member could not find. Records obtained for the month of September 2018, included strictly night shift temperatures that were taken and recorded by registered staff. Registered staff, when asked how the temperature was taken, provided an infrared laser thermometer, an inappropriate instrument for taking temperatures of liquids. Water temperature records were also incomplete on two identified home areas. Both records were missing seven days of water temperatures in September 2018. The VPER confirmed that no hot water temperature records were kept for day shift temperatures.

Records for the hot water temperatures taken by registered staff during the evening shift for the month of September 2018, in home areas included evening shift temperatures only.

The licensee's policy entitled "Maintenance – Water Temperature" policy 3.12 dated August 2018, was not developed in accordance with section 90 (2) (k) of Ontario Regulation 79/10. The policy included a requirement that a night shift housekeeping aide check the hot water temperatures daily in two separate locations in the home between 11 p.m and 7 a.m. and no further direction. The policy did not include a requirement that hot water temperatures be monitored on

each shift and how the water temperature would be monitored. No direction was provided as to what appropriate instrument would be used and how the instrument would be maintained. [s. 90. (2) (k)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks and to ensure that procedures are developed and implemented to ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents do not exceed 49 degrees Celsius (C), and is controlled by a device, inaccessible to residents, that regulates the temperature and to ensure that procedures are developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius (C) and to ensure that procedures are developed and implemented to ensure that if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water, to be implemented voluntarily.

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

In accordance with O. Reg. 79/10, s. 5. neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well- being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents.

Critical Incident #2779-000019-18 submitted to the MOHLTC on an identified date in August, 2018 was reviewed and it indicated that on an identified date in August, 2018, the home identified improper/incompetent treatment that resulted in harm or risk of harm, was provided to residents #053, #054, #055, #056, #057 and #075. It was noted that the management noticed the residents were not present for breakfast. When they inquired of the staff they were informed that due to staff shortages the staff were not able to get all residents to the dining room. The staff also reported that they did not provide the residents with between meal beverages and snacks for 12 weeks because they had been exempted from doing this. It was noted that the residents' relative(s), friend(s), designated contact(s) and/or substitute decision maker(s) were not contacted because it was discovered after investigation that breakfast had been offered once residents had been provided morning care.

Corporate staff #128 and the DOC confirmed the accuracy of the information as noted in the CI report.

The home did not ensure that the residents' SDM and any other person specified by the residents were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the residents as noted above. [s. 97. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's SDM and any other person specified by the resident are notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #32: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

Critical incident #2779-000008-18 was reviewed and it was noted that resident #004 was allegedly sexually abused on an identified date in April, 2018. The resident reported the alleged incident to the home on an identified date in April, 2018.

The clinical record of resident #004 was reviewed and indicated information as above.

On an identified date in August, 2018, the OPP was notified of the allegations from April, 2018. Corporate staff member #128 and the ADOC and DOC confirmed the accuracy of the information as contained in the resident's record and the CI report.

This area of non-compliance was identified in relation to CI #009768-18. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence, to be implemented voluntarily.

WN #33: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

“General Equipment Maintenance” policy 3.4, dated August 2018, included that plumbing fixtures such as water faucets and aerators would be inspected on a monthly basis, but did not include hoppers, toilets, tubs, sinks, showers, grab bars or washroom accessories such as toilet paper holders and soap and paper towel dispensers. It required that maintenance staff submit a completed preventive maintenance checklist to the Administrator monthly without any other direction as

to the appropriate time frames for follow up action, how the plumbing fixtures would be maintained and by whom.

During the inspection, rusted toilet paper holders, rust stains in toilet bowls and/or rusted sink drains were observed in but not limited to identified resident rooms. No special cleaning requirements were listed in the housekeeping or maintenance policies and procedures to address these issues. Audits conducted by housekeeping staff were documented on a form entitled "Environmental Room Audit". The form included "stained toilets" but no maintenance related issues such as corroded, cracked or unmaintained fixtures or accessories. No records of completed audits could be found by the Vice President of Environmental Resources for the rooms identified above.

A sink was missing from the clean utility room in a home area during the inspection. Staff completed a written electronic report that the sink was leaking on an identified date in August 2018. No follow-up action was documented.

A hopper in a home area soiled utility room could not be flushed on an identified date in September 2018. According to staff in that home area, a screw driver needed to be used to flush the water. Personal support workers (PSW's) completed a written maintenance electronic report that the flush handle was broken on an identified date in July 2018. No response was documented. Another report was submitted on an identified date in August 2018, with a note that a screw driver was being used. No response was included. A third report was submitted on an identified date in September 2018 and the response included that parts were on order and that staff were instructed to use the screw driver to flush the water.

A shower head in a home area shower room was tested during the inspection and was not functional. Water squirted out from the shower arm mount for the hand shower head but not the shower head. The DES was present and was unaware of the issue. The DES suspected that there was scale build-up in the shower head preventing proper water flow. The PSW's in the home area on the day shift were aware of the issue and stated it had not worked for years. No maintenance request submissions could be found in the home’s maintenance request software system.

Resident washroom sinks and hand sinks in activity rooms, soiled and clean utility rooms, nursing offices, dining rooms, an identified care room and tub rooms were

covered in scale in and around the faucets and faucet aerators. Water pressure was limited in the identified care room. A trend was identified of maintenance requests related to leaking tubs, toilets, sinks and pressure issues between January and September 2018. As the DES was not available, confirmation could not be made as to whether their policy 3.4 was implemented to inspect and replace the aerators, clean the excessive scale and monitor sinks and toilets for leaks. Although the home had a water softening system, verification could not be made as to whether the water softening system was adequately functional, or whether it supplied softened water to only certain areas of the home.

A bathing tub located in a home area was observed to have silicone caulking on the bottom of the surface of the tub interior. PSWs reported that they could not clean the bottom surface because the brush they used got stuck in the silicone. The DES was informed immediately about infection control concerns. On an identified date in September 2018, a technician from the tub manufacturer arrived and reported that the tub shell was cracked and silicone had been applied to try and seal the cracks, which was not appropriate. A new shell or lining was required. The tub was taken out of service. The tub was last fully inspected by the tub manufacturer in September 2017, at which time the tub was identified to be in good operating order. A review of the licensee's preventive maintenance check list for February 2018, provided by the Vice President of Environmental Resources (VPER), did not include the condition of the tubs as a task to be performed by in house maintenance staff.

The licensee therefore did not ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks. [s. 90. (2) (d)]

2. The licensee failed to ensure that procedures were developed and implemented to ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents did not exceed 49 degrees Celsius (C), and was controlled by a device, inaccessible to residents, that regulated the temperature.

"Maintenance – Water Temperature" policy 3.12 dated August 2018, was not developed in accordance with section 90 (2) (g) of Ontario Regulation 79/10. The policy included a requirement to ensure that the water temperature remained below 49C but did not include how that would be achieved or what follow up

actions (immediate and short term) would be necessary to reduce the water temperature or to ensure resident safety. No information was included regarding whether the hot water system was equipped with a device to regulate the water temperature.

The hot water supplied to areas of the home to which residents had access, such as showers and hand sinks in dining rooms, activity rooms, family laundry room and washrooms, was not controlled by a device that regulated the temperature. A tour of the mechanical room was conducted with the VPER. A mixing valve could not be located on any of the hot water lines in the room. On an identified date in April 2018, according to hot water records kept by registered staff, the water temperature at a hand sink in an identified room was 50.5C. Registered staff documented the exceeded temperature, but did not document what other action they took. According to electronic maintenance records, a maintenance person responded to this concern two days later, by stating that a quote was requested for a mixing valve. No further records could be provided that a mixing valve was ordered or installed. The VPER confirmed that no mixing valve was installed. [s. 90. (2) (g)]

3. The licensee failed to ensure that procedures were developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius (C).

“Maintenance – Water Temperature” policy 3.12, dated August 2018, was not developed in accordance with section 90(2)(i) of Ontario Regulation 79/10. The policy did not include any reference to monitoring the hot water temperature serving bathtubs or showers used by residents or how the temperature would be taken.

On an identified date in September 2018, the inspector randomly tested hot water temperatures using a probe stem thermometer [designed for liquids] in tub rooms and shower areas. The hot water temperature for the tub in a home area [which was equipped with built-in digital thermometer] was 38-39C and the tub in another home area was 35C, despite raising the digital thermostat to the maximum setting on the control panel to 40C and letting the water run for four minutes. According to the manufacturer’s instruction manual for the tubs in the home, a built-in thermostatic mixing valve controlled the water temperature and a maximum set point could be adjusted by a technician. The hot water temperature records

provided by registered staff for the month of September 2018, did not include temperatures taken at any of the seven tubs or five showers in the home. The registered staff also confirmed that a infrared laser thermometer was used to measure the water temperature at resident accessible hand sinks, which is not an accurate instrument for measuring the temperature of liquids. [s. 90. (2) (i)]

4. The licensee failed to ensure that procedures were developed and implemented to ensure that if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents had access to hot water.

During the inspection, confirmation was made that the hot water temperature was not monitored by a computerized system, but was taken manually by staff. On an identified date in September 2018, hot water records were requested from registered staff in each of the five home areas. All were obtained with the exception of an identified home area, which the registered staff member could not find. Records obtained for the month of September 2018, included strictly night shift temperatures that were taken and recorded by registered staff. Registered staff, when asked how the temperature was taken, provided an infrared laser thermometer, an inappropriate instrument for taking temperatures of liquids. Water temperature records were also incomplete on two identified home areas. Both records were missing seven days of water temperatures in September 2018. The VPER confirmed that no hot water temperature records were kept for day shift temperatures.

Records for the hot water temperatures taken by registered staff during the evening shift for the month of September 2018, in home areas included evening shift temperatures only.

The licensee's policy entitled "Maintenance – Water Temperature" policy 3.12 dated August 2018, was not developed in accordance with section 90 (2) (k) of Ontario Regulation 79/10. The policy included a requirement that a night shift housekeeping aide check the hot water temperatures daily in two separate locations in the home between 11 p.m and 7 a.m. and no further direction. The policy did not include a requirement that hot water temperatures be monitored on each shift and how the water temperature would be monitored. No direction was provided as to what appropriate instrument would be used and how the instrument would be maintained. [s. 90. (2) (k)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an identified restraint is applied according to manufacturer's instructions, to be implemented voluntarily.

WN #34: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident was reported to the resident's substitute decision-maker (SDM) and the prescriber of the drug.

A) A review of the home's medication incidents for the second quarter was completed. This review included an Incident Report for an identified date in May, 2018, regarding an incident of missed medication involving resident #071.

Upon review of the incident report, it was identified that the resident's SDM was not notified of the missed medication. Under the heading "Agencies/People Notified" the area indicates that only the physician was notified.

Interview with the registered staff #123 identified that they did not notify family of the incident as described. During the interview it was confirmed that they were the person who filled out the incident report and found the error.

Interview with the RAI Coordinator #131 identified that based on their internal investigation, resident #071's SDM was not notified of the medication incident.

The licensee failed to ensure that every medication incident involving a resident is reported to the resident's SDM.

B) A review of the home’s medication incidents for the second quarter was completed. This review included an incident on an identified date in May, 2018, regarding an incident of missed medications involving resident #070.

Upon review of the incident report, it was identified that the resident's SDM or the physician was not notified of the missed medication. Under the heading "Agencies/People Notified" the area indicates that "no notification found".

Interview with the registered staff #116 identified that they did not notify the resident's SDM or the resident's physician of the missed medications. During the interview it was confirmed that they were the person who filled out the incident report and found the error.

Interview with the RAI Coordinator #131 identified that based on their internal investigation, resident #070's SDM and the physician were not notified of the medication incident.

The licensee failed to ensure that every medication incident involving a resident is reported to the resident's SDM and the prescriber of the drug.

C) A review of the home’s medication incidents for the second quarter was completed. This review included an incident on an identified date in June, 2018, regarding an incident of dosage transcription error that involved resident #061 receiving an incorrect dosage of medication. Under the heading

"Agencies/People Notified" the area indicates that only the physician was notified.

Interview with the registered staff #123 identified that they did not notify the resident's SDM of the error. During the interview it was confirmed that they were the person who completed the incident report and found the error.

Interview with the RAI Coordinator #131 identified that based on their internal investigation, resident #061's SDM was not notified of the medication incident.

The licensee failed to ensure that every medication incident involving a resident is reported to the resident's SDM. [s. 135. (1)]

2. The licensee failed to ensure that all medication incidents were reviewed, analyzed and corrective actions were taken; and a written record was kept of everything.

A) A review of the home's medication incidents for the quarter was completed. This review included an an identified date in May, 2018, regarding an incident of missed medication involving resident #071.

Review of a report titled "Medication Incident - Final Report: MEDCINC27847", indicated that this medication incident was not investigated. As documented under the heading "Investigated?" the report reads "No-report accepted as written". Sections headings Interventions and Investigation Notes have been left blank with no information provided.

Interview with the RAI Coordinator #131 identified that no investigation was completed into this medication incident involving resident #071. They confirmed that there was no documentation available for this incident related to analysis or corrective action.

The licensee failed to ensure that the medication incident involving resident #071 was reviewed, analyzed and corrective actions were implemented.

B) A review of the home's medication incidents for a three month period of time was completed. This review included an identified date in May, 2018, regarding an incident of missed medications involving resident #070.

Review of a report titled "Medication Incident - Final Report: MEDCINC27616" , indicated that this medication incident was not investigated. As documented under the heading "Investigated?” the report reads "No-report accepted as written". Sections headings Interventions and Investigation Notes have been left blank with no information provided.

Interview with the RAI Coordinator #131 identified that no investigation was completed into this medication incident involving resident #070. They confirmed that there was no documentation available for this incident related to analysis or corrective action.

The licensee failed to ensure that the medication incident involving resident #070 was reviewed, analyzed and corrective actions were implemented. [s. 135. (2)]

3. The licensee failed to ensure that, (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions and any changes and improvements identified in the review were implemented and a written record was kept of everything provided for in clauses (a) and (b).

During an interview with the RAI Coordinator #131, documentation was provided of the home’s quarterly review of all medication incidents since the time of the last review. A review of documentation from April 2018 to June 2018, indicated that during a Professional Advisory Committee (PAC) meeting, a list of the types of medication errors had been documented, however, no further documentation was included to identify a review of these incidents or any changes and improvements. They also provided a copy of the Clinical Consultant Pharmacist Report for the same time period which contained a table that identified all medication incidents. No documentation was available to identify the plan to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review are implemented, and a written record was kept of everything.

During an interview with Consultant Pharmacist #125, they reported that the medication incidents were discussed, however no interventions or actions to prevent further incidents were discussed. They further reported that they had made several suggestions to the management of the home to have monthly or even quarterly reviews with assessments and actions to address medication

incidents and no action was taken by the home.

An interview with RAI/MDS Coordinator #131 confirmed that a quarterly review of all medication incidents in the home including any changes or improvements since the last time of the last review in order to reduce and prevent medication incidents had not been completed.

The RAI/MDS Coordinator #131 confirmed that the home failed to review medication incidents at least quarterly in order to reduce and prevent medication incidents and any changes and improvements identified in the review were implemented. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident is reported to the resident's substitute decision-maker (SDM) and the prescriber of the drug and to ensure that all medication incidents are reviewed, analyzed and corrective actions are taken; and a written record is kept of everything and to ensure that, (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions and any changes and improvements identified in the review are implemented and a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #35: 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. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

“General Equipment Maintenance” policy 3.4, dated August 2018, included that plumbing fixtures such as water faucets and aerators would be inspected on a monthly basis, but did not include hoppers, toilets, tubs, sinks, showers, grab bars or washroom accessories such as toilet paper holders and soap and paper towel dispensers. It required that maintenance staff submit a completed preventive maintenance checklist to the Administrator monthly without any other direction as to the appropriate time frames for follow up action, how the plumbing fixtures would be maintained and by whom.

During the inspection, rusted toilet paper holders, rust stains in toilet bowls and/or rusted sink drains were observed in but not limited to identified resident rooms. No special cleaning requirements were listed in the housekeeping or maintenance policies and procedures to address these issues. Audits conducted by housekeeping staff were documented on a form entitled "Environmental Room Audit". The form included "stained toilets" but no maintenance related issues such as corroded, cracked or unmaintained fixtures or accessories. No records of completed audits could be found by the Vice President of Environmental Resources for the rooms identified above.

A sink was missing from the clean utility room in a home area during the inspection. Staff completed a written electronic report that the sink was leaking on

an identified date in August 2018. No follow-up action was documented.

A hopper in a home area soiled utility room could not be flushed on an identified date in September 2018. According to staff in that home area, a screw driver needed to be used to flush the water. Personal support workers (PSW's) completed a written maintenance electronic report that the flush handle was broken on an identified date in July 2018. No response was documented. Another report was submitted on an identified date in August 2018, with a note that a screw driver was being used. No response was included. A third report was submitted on an identified date in September 2018 and the response included that parts were on order and that staff were instructed to use the screw driver to flush the water.

A shower head in a home area shower room was tested during the inspection and was not functional. Water squirted out from the shower arm mount for the hand shower head but not the shower head. The DES was present and was unaware of the issue. The DES suspected that there was scale build-up in the shower head preventing proper water flow. The PSW's in the home area on the day shift were aware of the issue and stated it had not worked for years. No maintenance request submissions could be found in the home's maintenance request software system.

Resident washroom sinks and hand sinks in activity rooms, soiled and clean utility rooms, nursing offices, dining rooms, an identified care room and tub rooms were covered in scale in and around the faucets and faucet aerators. Water pressure was limited in the identified care room. A trend was identified of maintenance requests related to leaking tubs, toilets, sinks and pressure issues between January and September 2018. As the DES was not available, confirmation could not be made as to whether their policy 3.4 was implemented to inspect and replace the aerators, clean the excessive scale and monitor sinks and toilets for leaks. Although the home had a water softening system, verification could not be made as to whether the water softening system was adequately functional, or whether it supplied softened water to only certain areas of the home.

A bathing tub located in a home area was observed to have silicone caulking on the bottom of the surface of the tub interior. PSWs reported that they could not clean the bottom surface because the brush they used got stuck in the silicone. The DES was informed immediately about infection control concerns. On an identified date in September 2018, a technician from the tub manufacturer arrived

and reported that the tub shell was cracked and silicone had been applied to try and seal the cracks, which was not appropriate. A new shell or lining was required. The tub was taken out of service. The tub was last fully inspected by the tub manufacturer in September 2017, at which time the tub was identified to be in good operating order. A review of the licensee's preventive maintenance check list for February 2018, provided by the Vice President of Environmental Resources (VPER), did not include the condition of the tubs as a task to be performed by in house maintenance staff.

The licensee therefore did not ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks. [s. 90. (2) (d)]

2. The licensee failed to ensure that procedures were developed and implemented to ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents did not exceed 49 degrees Celsius (C), and was controlled by a device, inaccessible to residents, that regulated the temperature.

"Maintenance – Water Temperature" policy 3.12 dated August 2018, was not developed in accordance with section 90 (2) (g) of Ontario Regulation 79/10. The policy included a requirement to ensure that the water temperature remained below 49C but did not include how that would be achieved or what follow up actions (immediate and short term) would be necessary to reduce the water temperature or to ensure resident safety. No information was included regarding whether the hot water system was equipped with a device to regulate the water temperature.

The hot water supplied to areas of the home to which residents had access, such as showers and hand sinks in dining rooms, activity rooms, family laundry room and washrooms, was not controlled by a device that regulated the temperature. A tour of the mechanical room was conducted with the VPER. A mixing valve could not be located on any of the hot water lines in the room. On an identified date in April 2018, according to hot water records kept by registered staff, the water temperature at a hand sink in an identified room was 50.5C. Registered staff documented the exceeded temperature, but did not document what other action they took. According to electronic maintenance records, a maintenance person responded to this concern two days later, by stating that a quote was requested

for a mixing valve. No further records could be provided that a mixing valve was ordered or installed. The VPER confirmed that no mixing valve was installed. [s. 90. (2) (g)]

3. The licensee failed to ensure that procedures were developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius (C).

"Maintenance – Water Temperature" policy 3.12, dated August 2018, was not developed in accordance with section 90(2)(i) of Ontario Regulation 79/10. The policy did not include any reference to monitoring the hot water temperature serving bathtubs or showers used by residents or how the temperature would be taken.

On an identified date in September 2018, the inspector randomly tested hot water temperatures using a probe stem thermometer [designed for liquids] in tub rooms and shower areas. The hot water temperature for the tub in a home area [which was equipped with built-in digital thermometer] was 38-39C and the tub in another home area was 35C, despite raising the digital thermostat to the maximum setting on the control panel to 40C and letting the water run for four minutes. According to the manufacturer's instruction manual for the tubs in the home, a built-in thermostatic mixing valve controlled the water temperature and a maximum set point could be adjusted by a technician. The hot water temperature records provided by registered staff for the month of September 2018, did not include temperatures taken at any of the seven tubs or five showers in the home. The registered staff also confirmed that a infrared laser thermometer was used to measure the water temperature at resident accessible hand sinks, which is not an accurate instrument for measuring the temperature of liquids. [s. 90. (2) (i)]

4. The licensee failed to ensure that procedures were developed and implemented to ensure that if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents had access to hot water.

During the inspection, confirmation was made that the hot water temperature was not monitored by a computerized system, but was taken manually by staff. On an identified date in September 2018, hot water records were requested from registered staff in each of the five home areas. All were obtained with the

exception of an identified home area, which the registered staff member could not find. Records obtained for the month of September 2018, included strictly night shift temperatures that were taken and recorded by registered staff. Registered staff, when asked how the temperature was taken, provided an infrared laser thermometer, an inappropriate instrument for taking temperatures of liquids. Water temperature records were also incomplete on two identified home areas. Both records were missing seven days of water temperatures in September 2018. The VPER confirmed that no hot water temperature records were kept for day shift temperatures.

Records for the hot water temperatures taken by registered staff during the evening shift for the month of September 2018, in home areas included evening shift temperatures only.

The licensee's policy entitled "Maintenance – Water Temperature" policy 3.12 dated August 2018, was not developed in accordance with section 90 (2) (k) of Ontario Regulation 79/10. The policy included a requirement that a night shift housekeeping aide check the hot water temperatures daily in two separate locations in the home between 11 p.m and 7 a.m. and no further direction. The policy did not include a requirement that hot water temperatures be monitored on each shift and how the water temperature would be monitored. No direction was provided as to what appropriate instrument would be used and how the instrument would be maintained. [s. 90. (2) (k)]

Additional Required Actions:

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

WN #36: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of sleep patterns and preferences with respect to the resident.

A) A complaint was received that identified a visitor was in to see resident #074 on an identified date in June, 2018, and the resident was still in bed at an identified time and had to ask staff to assist the resident with personal care. On an identified date in July, 2018, resident #074 was observed in bed and was not taken to the dining room for breakfast. The progress notes were reviewed from identified dates in July, 2018, and it was documented multiple times that the resident slept in and had no intake at breakfast.

Resident #074 could not identify their preferences related to sleep routine or meals. In an interview with resident #074's SDM, it was confirmed that they had never been asked to provide information related to resident #074's sleep patterns or preferences. It was the SDM's understanding the resident was getting up in the morning and eating three meals in the dining room.

In an interview with the RAI/MDS Coordinator, it was confirmed that as of July, 2018, there was no interdisciplinary assessment of resident #074's sleep patterns and preferences and that it was not part of the resident's plan of care to stay in bed through the breakfast service.

This area of non-compliance was identified in relation to Complaint #012432-18.

B) CI report #2779-000019-18 submitted to the MOHLTC on an identified date in August, 2018, was reviewed. It was identified that the DOC observed residents #053, #054, #055, #056, #057 and #075 were missing from the dining room. PSW #111 was questioned and reported that due to staff shortages, they were not able to get all residents to the dining room. The DOC instructed the PSW that all residents must come to the dining area unless indicated in the plan of care that

the residents preferred otherwise.

The records of the residents noted above were reviewed including the care plans. The care plans of residents #053, #054, #056, #057 and #075 did not include a focus related to sleep.

Interview with the DOC reported that the residents were not to remain in bed but were to be up for breakfast. The DOC confirmed that the residents' plans of care were not based on an interdisciplinary assessment of the residents' sleep patterns and preferences.

This area of non-compliance was identified in relation to CI inspection #020603-18. [s. 26. (3) 21.]

WN #37: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that each of the organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there was a written description of the program that included its: goals and objectives; relevant policies, procedures, protocols; methods to reduce risk and monitor outcomes and protocols for referral of residents to specialized resources where required.

The home was requested to produce their written description of the Nursing and Personal Support Services program. The home did not produce the written description of the program. Corporate staff #128 and the DOC confirmed a

written description of the Nursing and Personal Support Services program was not available.

The home did not ensure there was a written description of the Nursing and Personal Support Services program which included all the above information.

This area of non-compliance was identified in relation to Complaint #018920-18. [s. 30. (1) 1.]

2. The licensee failed to ensure that a written record was kept relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The home failed to keep a written record of the evaluation for skin and wound, and falls as confirmed with the ADOC on August 21, 2018. [s. 30. (1) 4.]

3. The licensee failed ensure that any actions taken with respect to a resident under program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A complaint was received by MOHLTC in March, 2018 alleging that resident #098 was not being provided specified care. A clinical record review for resident #098 identified that staff were to check the resident before and after meals, at bed time and on rounds during the night. In May, 2018, the point of care (POC) task report showed that the resident received incontinence care at an identified time and did not receive any further incontinence care until 17 hours later.

The ADOC confirmed that all care provided was to be documented on the POC documentation system.

This area of non-compliance was identified in relation to Complaint #006339-18. [s. 30. (2)]

4. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A complaint was received by MOHLTC in June, 2018 regarding the SDM of

resident #200 having concerns related to care issues and areas of altered skin integrity. The SDM reported these concerns to registered staff #127 and the staff assessed the resident as requested and spoke with the SDM about their care concerns. A review of the clinical record confirmed that there was no documentation regarding the above or the resident receiving an assessment from the registered staff.

Interview with registered staff #127 in September, 2018, confirmed they remembered having a discussion with the SDM assessing the resident and felt that there were no areas of altered skin integrity. Registered staff #127 confirmed that they did not document the discussion with the SDM or their assessment of the resident.

Interview with the ADOC confirmed that all assessments and discussions with the family regarding care concerns should have been documented in the resident's clinical record.

The area of non-compliance was identified in relation to Complaint #0012534-18. [s. 30. (2)]

5. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Critical Incident report #2779-000019-18 submitted to the MOHLTC in August, 2018, indicated residents #053, #054, #055, #056, #057 and #075 were not provided identified aspects of personal care due to being short staffed. The inspection into whether those aspects of care were provided necessitated a review of the residents' POC documentation for the twelve week period indicated in the CI report. A review of the POC documentation revealed multiple blank spaces where the staff did not document care provided related to the areas indicated in the CI report.

The resident's records were reviewed including the POC documentation for May, June and July 2018. Not all personal care interventions were documented. There were blank spaces on the POC documents in all three months as confirmed through record review.

The home did not ensure that any actions taken with respect to residents #053,

#054, #055, #056, #057 and #075 under a program were documented.

The area of non-compliance was identified in relation to CI inspection #020603-18. [s. 30. (2)]

WN #38: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter.

The homes' weight monitoring system was not implemented. Resident #094 did not have their weight measured or recorded for an identified month in 2018, as confirmed by clinical record and interview with the ADOC. [s. 68. (2) (e) (i)]

WN #39: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee sought the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

The home completed a satisfaction survey in 2018, however, as confirmed by the Family Council and the Administrator, the home did not seek the advice of the council in developing and carrying out the survey and in acting on its results. [s. 85. (3)]

WN #40: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows:
1) The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2) For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3) A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

"Process for Complaints " policy last reviewed April 2016, directed staff that all complaints, whether verbal, email, written or voice mail should be documented on the Client Service Response Form (CSRF) and Resolution Form for performance quality.

A complaint was made to the Inspector on an identified date in August, 2018, that the licensee was not following their complaints procedure. The complainant informed the Inspector that they emailed the ADOC on an identified date in July, 2018, to inform them that resident #098 sustained an injury on an identified date in July, 2018, while the PSW’s were providing care. The ADOC confirmed, that they received this complaint on an identified date in July, 2018, and forwarded the concern to the former Administrator of the home.

A review of the home’s complaint logs did not identify a CRSF regarding this complaint. In an interview with the DOC/Acting Administrator and Corporate ED, they confirmed it was the home's expectation that the CSRF be completed when a resident or family member expressed a concern or a complaint and confirmed that the licensee failed to ensure the complaint process was followed.

The area of non-compliance was identified in relation to Complaint #006339-18.
[s. 101. (1) 1.]

Issued on this 11st day of April, 2019 (A1)

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MELODY GRAY (123) - (A1)
Inspection No. / No de l'inspection :	2018_695156_0006 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	016725-18 (A1)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 27, 2019(A1)
Licensee / Titulaire de permis :	Park Lane Terrace Limited 284 Central Avenue, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	Park Lane Terrace 295 Grand River Street North, PARIS, ON, N3L-2N9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mike Schmidt

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Park Lane Terrace Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee must be compliant with s. 76 (2) of the LTCHA.

Specifically the licensee must:
1. Ensure agency PSW's: #200, #201, #202, #203, #204, #205, and agency registered staff #206, #207, #208 and #209 and all other agency staff working in the home receive training on areas identified below before working in the home.

2. The home will develop, implement and record an auditing process to ensure that agency staff working in the home have received training prior to working in the home.

3. Training of designated agency staff and all agency staff working in the home will maintained in the home.

Grounds / Motifs :

(A1)
1. The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the areas mentioned below: 1. The Residents’ Bill of Rights. 2. The long-term care home’s mission statement. 3. The long-term care home’s policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home’s policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person’s responsibilities. 11. Any other areas provided for in the regulations.

A complainant was interviewed and reported to the Inspector that the staff who provided care to the resident did not receive any orientation prior to working on the home area.

The home's Daily Assignment Sheets, the Orientation and Annual Education Binder - Agency and the Orientation and Annual Education Binder - Contract Staff were reviewed with the ADOC. Six of the staff identified as agency PSW's: #200, #201, #202, #203, #204, #205, and four agency registered staff #206, #207, #208 and #209 who were noted as having worked during the above time period did not have dates and signatures documented indicating they had reviewed the required orientation material. The ADOC confirmed the agency staff noted above did not receive the required training prior to performing their responsibilities as noted above.

The non-compliance was issued as a CO. The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 2 as it was a pattern. The home had a level 3 history as there was one or more related non-compliance in the last thirty six months with a VPC under the same section May 24, 2017. (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 15, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, r. 31 (3).

Specifically the licensee must:
Prepare, submit and implement a written plan to ensure that there is a written staffing plan.
The plan must include, but is not limited, to the following:
1. A description of a staffing plan that will be implemented for all home areas that will provide a staffing mix that will meet residents' assessed care and safety needs.
2. A description of an auditing process that will be used to evaluate if resident care needs are being met on a daily basis.
i) Include how staff shortages will be tracked.
ii) Include how the home will identify, track and document any resident care or safety needs that are identified when there are staff shortages.
iii) Include a plan on what action will be taken to meet care and safety needs in these circumstances.
iv) Identify who will evaluate the audits and what frequency they will be completed.
3. A description of a backup plan that will be put in place when Personal Support Workers and Registered Practical Nurses cannot come to work. Include who will be responsible for implementing the plan.
4. A description of what strategies the licensee will use to promote continuity of care for residents.
5. A description of what strategies the licensee will use to maximize the recruitment and retention of staff.
Identify how all of the above information will be documented and recorded.

Please submit the written plan for achieving compliance for, 2018_695156_0006 to Carol Polcz, LTC Homes Inspector, MOHLTC, by email to HamiltonSAO.moh@ontario.ca by January 31, 2019.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

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

Park Lane Terrace is a 132 bed capacity LTC home with approximately 24 to 30

residents in each of the five home areas. The Ministry of Health and Long-Term Care (MOHLTC) received complaints including, #016094-18; #018007-18; #018113-18; #018378-18; #018920-18 and #012534-18 about inadequate nursing department staffing in the home which was impacting the personal care and services provided to the residents including: continence care; dressing and grooming and hygiene. Inspectors arrived at the home on July 2018 and for approximately two weeks they received additional complaints related to lack of sufficient nursing department staffing which resulting in residents not being provided aspects of personal care.

On an identified date in August 2018, Corporate staff #120, the DOC and the ADOC confirmed that aspects of personal care and morning between-meal beverages and nourishments were not being provided to residents due to inadequate nursing department staffing. The home submitted CI report #2779-000019-18 to the MOHLTC on that day reporting staff to resident neglect of residents #053, #054, #055, #056, #057 and #075. The CI report indicated aspects of personal care and morning between meal beverages and nourishments were not provided to residents over the previous twelve weeks due to inadequate nursing department staffing.

The staffing shortages took place during the twelve weeks prior to the identified date as confirmed with Corporate staff #120, #128, the DOC, the ADOC and the Staffing Clerk. They reported the home made changes to the nursing department staffing from April 2018 to July 2018. Corporate staff #128 reported that in April 2018, the home made reductions in the nursing department staffing plan after the Case Mix Index (CMI) was reduced. The home's corporate office was aware of this change and the plan was that the home would gradually increase the nursing department staffing as funds became available through the year. It was reported that the former Administrator independently made further changes to the staffing plan which included creating shorter shifts that were difficult to fill and changing or deleting some shifts which resulted in a staffing mix which did not meet the assessed needs of the residents and the staff could not provide adequate care to the residents. There were not enough nursing staff on the day and evening shifts to provide the care the residents needed.
The staffing pattern that impacted the residents noted in the CI report, who did not receive the nourishments and other aspects of personal care was in effect in July 2018.
The home's April 2018 staffing plan, prior to the changes and the July 2018 staffing plan that was in effect at the beginning of the inspection were reviewed with the

Staffing Clerk.

It was noted that in April 2018, the home's nursing department staffing pattern provided: six registered staff and 21 PSWs during the day shift; five registered staff and 14 PSWs during the evening shift and two registered staff and eight PSWs during the night shift.
The July 2018, the staffing plan indicated that there were five registered staff and 17 PSWs working during the day shift; five registered staff and 11 PSW staff during the evening shift and two registered staff and eight PSWs during the night shift as confirmed with the Staffing Clerk.
This represented a decrease in one registered staff and four PSW staff for the day shift, and a decrease of three PSW staff during the evening shift.

On identified home areas, the changes from April 2018 to July 2018, included a two hour reduction in registered nursing hours and a reduction of nine PSW staffing hours during the day shift. Also, there was one PSW working by themselves on identified home areas alone for half an hour each day at an identified time.
On another home area during the day shift, the registered staffing hours were extended by two hours. The PSW hours were reduced by eight hours and there was one PSW on the home area at an identified time.
On another home area there was a reduction in nursing and PSW hours as well.
The changes in the home's nursing department staffing plan from April 2018 to July 2018 resulted in fewer registered nursing hours and fewer PSW hours. It also resulted in one PSW working between identified times on four of the five home areas.

On an identified date in July 2018, a specified staff member was observed to be wearing 'scrubs'. When questioned by the inspectors (#506, #123 and #156) as to why they were wearing scrubs, the specified staff member responded that "they were acting as a PSW today". PSW #110 and #109 confirmed that the specified staff member did this approximately once per month which was also confirmed by the Administrator. The Employee Services Coordinator confirmed that they were short staffed on the identified date in July 2018.

The home's nursing department staffing plan was reviewed and the staff deployment was observed throughout the home on multiple occasions during the inspection. Registered staff, PSWs, the home's nursing department management and corporate

staff confirmed the home's staffing plan did not provide a staffing mix that was consistent with residents' assessed care and safety needs. As a result of the nursing department staff shortages residents' did not receive the personal care they required.

The internal staff bulletin board was observed and there were nine job postings for PSW staff: one full-time and eight part- time. Corporate staff #128 reported that in order to meet the care needs of the residents, an additional 10 to 15 staff members, including five RPNs and two RNs were required. Shortage of staff would be addressed by utilizing an identified staffing agency for non-registered nursing department staff. Corporate staff #128 and the DOC also reported the home would immediately start calling applicants for interviews for the positions that were already posted to the public. On-boarding could take up to six weeks and staff would start as soon as possible if all police checks were completed.

PSWs reported to the Inspector that they did not descale the tubs due to time restrictions. According to several housekeeping staff, the tub rooms and soiled utility rooms were not cleaned due to cuts in housekeeping hours, if they were running behind schedule due to cleaning emergencies, or having been asked to assist PSWs with tasks such as portering residents to dining rooms, assisting with meals, assisting with resident's lifts and transfers and other duties not specifically assigned.

The staffing plan did not provide for a staffing mix that was consistent with residents' assessed care and safety needs:

A) The home submitted a CI report #2779-000019-18 to the MOHLTC on an identified date in August 2018, reporting improper/incompetent treatment of six identified residents which they attributed to nursing department staffing shortages over a twelve week period. It was noted that two days prior, the DOC and ADOC were present when it was noticed that there were residents missing from the breakfast area. PSW #111 was questioned and they reported that due to staff shortages they were not able to get all of the residents up for breakfast. PSW #111 reported residents #053, #054, #055, #056, #057 and #075 were in bed because they did not have time to provide care to them. PSW #111 reported they had been told they were exempted from doing the snack cart twelve weeks prior by the former Administrator and former DOC. PSWs, registered staff, the ADOC, DOC and corporate staff #128 confirmed the information as noted in the CI report.

The home's staffing pattern for the twelve week period ending on an identified date in August 2018 did not meet the assessed care needs of residents #053, #054, #055, #056, #057 and #075.

B) Resident #072 reported to the Inspector that they were not provided care to manage their incontinence as required between identified hours daily because the home did not have enough staff available as the staff could not leave the dining room during the daily meal service.

The home's nursing and personal support staffing plan was reviewed. The nursing and personal support staffing deployment in the dining room was observed on multiple occasions throughout the inspection.

Registered staff #123 was interviewed and reported that resident #072 had incontinence and required the assistance of staff. The staff could not leave the dining room during meals because they had to serve, feed and supervise the residents. They confirmed resident #072 was not toileted during identified hours as there were not enough nursing and personal support staff available to do so.

The home did not ensure that the nursing and personal support staffing plan provided for a staffing mix that was consistent with resident #072's assessed care and safety needs.

C) On an identified date in July 2018, resident #060 was observed by the inspector to have signs of incontinence. The resident was observed again an hour and a half later where it was noted the resident still had signs of incontinence. A review of the clinical record related to continence care confirmed that the staff were to check resident #060 for wetness due to urinary incontinence and toilet the resident if they were wet. An hour and a quarter later, the resident was again observed and it was noted that the resident still exhibited signs of urinary incontinence including wetness. Interview with RPN #106 confirmed that the resident was to be checked for wetness at an identified time and confirmed resident #060 demonstrated signs of urinary incontinence. PSW #105 confirmed resident #060 was not checked for incontinence or toileted as directed by their care plan due to the unit being short staffed. (506)

D) Resident #040 was observed covered in a hospital gown and blanket on an

identified date in July 2018 until after lunch by inspectors #156 and #506 at two different times of day. A review of the plan of care for this resident did not indicate that it was their preference not to be dressed. PSW staff #111 and #117 confirmed that the resident was not dressed that day until after lunch as they were short staffed. The home did not ensure that the nursing and personal support staffing plan provided for a staffing mix that was consistent with resident #040's assessed care and safety needs.(156)

E) During the inspection, it was reported to the Inspector that resident #015 was left in their pajamas.

On an identified date in August 2018, resident #015 was observed in their pajamas and a robe in the afternoon. PSW #138 reported the resident was not dressed because it was their bath day. The home was understaffed and there was not enough time. The DOC observed resident #015 dressed in pajamas and a robe and confirmed the resident was not assisted in getting dressed as required.

F) Bathing was not offered twice a week due to staffing shortages:

a) In an interview with PSW #144 on an identified date in July 2018, it was reported that the home was short staffed and residents who had scheduled baths on the identified home areas on two identified dates in July 2018, did not receive baths as well as the resident who had baths scheduled on another identified date in July 2018.

b) The “Daily Assignment Sheets” were reviewed from identified dates in July 2018. In addition to the staff shortages noted above, the following staff shortages were confirmed with the Employee Services Coordinator on August 16, 2018.

On two home areas:
i) On three identified dates in July 2018, no PSW staff were available for bath shift from 0600 to 1200 hours.
ii) On two identified dates in July 2018, no PSW staff were available for the bath shift from 1430 to 2100 hours.
iii) On one identified date in July 2018, short one PSW from 0630 to 1430 hours.

On three other home areas:
i) On three identified dates in July 2018, no PSW staff were available for the bath

shift from 0600 to 1400 hours.
ii) On one identified date in July 2018, no PSW staff were available for the bath shift from 1300 to 2100 hours.

In an interview with RPN #142 and PSW #144 it was reported that residents scheduled baths were often missed when scheduled bath shift PSWs were not available. It was reported that the home did not have a process in place to make up/reschedule residents missed baths.

The following shift shortages were also confirmed on the units listed:
iii) On an identified date in July 2018, short one PSW staff on an identified home area from 0600 to 1400 hours.
iii) On an identified date in July 2018, short one PSW staff on an identified home area from 0600 to 1400 hours.
iv) On an identified date in July 2018, short one PSW staff on an identified home area from 0600 to 1400 hours.
v) On an identified date in July 2018, short one PSW staff on an identified home area from 0630 to 1430 hours.
vi) On an identified date in July 2018, short one PSW staff on an identified home area from 0600 to 1400 hours.

In an interview with RPN #142 as well as in interview with PSW #144 it was reported that when there were shortages on the unit, the scheduled bath shift PSW would be required to assist with other resident care responsibilities and scheduled baths were not be completed. (583)

c) Staff were to refer to a "Bathing List" for frequency and specific dates for resident #057. The resident confirmed that they preferred to have a bath on identified days of the week, but on certain days, due to short staffing, they did not get a bath on their preferred days. The resident stated that they received a bath on an identified date in September 2018, but no other baths for two weeks prior.

The home did not ensure that the nursing and personal support staffing plan provided for a staffing mix that was consistent with resident #057's assessed care and safety needs. (123) [s. 31. (3) (a)]

The non-compliance was issued as a CO. The severity of this issue was determined

to be a level 2 as there was potential for actual harm. The scope of the issue was a level 3 as it was widespread. The home had a level 2 compliance history as there was one or more unrelated non-compliance in the last 36 months. (123)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 17, 2019

Order # / Ordre no : 003 **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 O. Reg. 79/10, r. 33 (1).

Specifically the licensee must:
1. Ensure that residents #156, #101, #102, #104, #007, #105, #106, #107, #004, #115, #117, #108, #062, #109, #110, #111, #112, #113, #114, #057, #053, #054, #055, #056 and #075 and all other residents are 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.
2. Develop a plan to ensure that missed baths are made up within the scheduled week
3. Develop, implement and document an auditing process to ensure that bathing is being completed biweekly for all residents

Grounds / Motifs :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) In an interview with resident #156, they reported that they did not receive a bath on an identified date in July, 2018. The resident confirmed they were not offered a rescheduled bath.

In an interview with PSW #144, they confirmed resident #156's bath was not completed or rescheduled. PSW #144 also reported that residents who had scheduled baths on identified home areas on two identified dates in July, 2018 were not completed as well as the scheduled baths on another identified date in July, 2018.

Point of Care (POC) bathing documentation was reviewed for the dates and times identified above where PSW #144 identified resident bathing was missed.

i) On an identified date in July, 2018, there was no documentation that resident #101, #102 and #104 scheduled baths were completed or offered and there was no documentation to show their baths were rescheduled.

ii) On an identified date in July, 2018, there was no documentation that resident #007, #105, #106, #107 and #004's scheduled baths were completed or offered and there was no documentation to show the baths were rescheduled. It was documented that two identified residents received a bed bath instead of their preferred choice.

iii) On an identified date in July, 2018, there was no documentation that resident #108, #062, #109, #110, #111, #112, #113 and #114's scheduled baths were completed or offered and there was no documentation to show their baths were rescheduled.

The residents did not receive a bath a minimum of twice per week during the identified time period.

In an interview with resident #156, PSW bathing staff #144 and through a review of the bathing documentation in POC, it was confirmed that not all residents were being bathed a minimum of two times per week. (583)

B) Staff were to refer to a "Bathing List" for frequency and specific dates for bathing for resident #057. The resident confirmed that they preferred to have a bath on identified days of the week, but on certain days, due to short staffing, they did not get a bath on their preferred days. The resident stated that they received a bath on an identified date in September, 2018, but no other baths for two weeks prior.

The POC bathing documentation "Follow-up Question Report" for the period of twelve identified dates in September, 2018, revealed that staff #167 documented on an identified date in September, 2018, "not applicable" and a staff member documented that the resident refused their bath on another identified date in September, 2018. No other documentation was made as to whether the resident received a bath, shower or bed bath during this time period. (120)

C) CI report #2779-000018 submitted to the MOHLTC was reviewed. The clinical records including the care plans, progress notes and the May, June and July 2018, POC documentation of residents #053, #054, #055, #056, #057 and #075 were reviewed. All residents were noted to require the assistance of staff for transfers and bathing.

The review of the May 2018, POC documentation indicated:
i) Resident #053 received five baths and not applicable was indicated six times.
ii) Resident #055 received seven baths and not applicable two times.
iii) Resident #075 received six baths; refused one bath and not applicable was noted four times.

The review of June 2018, POC documentation indicated:
i) Resident #053 received six baths and not was not applicable seven times.
ii) Resident #054 received four baths; refused two baths; not applicable noted for one bath; not available for one bath and no documentation with blank space observed for one bath.
iii) Resident #055 received five baths and not applicable noted two times.
iv) Resident #057 received three baths; refused three baths and not applicable once.

v) Resident #075 received four baths and not applicable was noted four times.

The review of the July 2018, POC documentation indicated:
i) Resident #053 received seven baths; not applicable four times.
ii) Resident #054 received six baths and not applicable was noted three times.
iii) Resident #055 received five baths and not applicable five times.
iv) Resident #056 received seven baths and not applicable once.
v) Resident #076 received six baths and not applicable was noted two times.

Interview with PSW's and the DOC confirmed each resident of the home was not bathed, at a minimum, twice weekly by the method of their choice.

Through completion of interviews with residents and staff, reviews of Point of Care documentation and reviews of staff shortages on the daily assignment sheet it was confirmed that each resident in the home was not being bathed a minimum of twice per week. [s. 33. (1)]

The non-compliance was issued as a CO. The severity of this issue was determined to be a level 1 as there was minimal risk. The scope of the issue was a level 3 as it was widespread. The home had a level 3 history as there was one or more related non-compliance in the last 36 months with a WN under the same section on May 27, 2016. (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2019

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, r. 36.

Specifically the licensee must:
1. Ensure that staff use safe transferring and positioning devices or techniques when assisting resident #041 and all other residents.
2. Provide safe transferring and positioning retraining for staff #101 and #110.
3. Develop, implement and record an auditing process to ensure that resident #041 and all other residents requiring the use of a mechanical lift are safely transferred.

Grounds / Motifs :

(A1)
1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Critical incident (CI) report #2779-000020-18 submitted to the MOHLTC in relation to an alleged incident of improper care on an identified date in August 2018, was reviewed. The clinical record of resident #041 including the progress notes was reviewed. Resident #041 required a specified level of assistance for transfers. On an identified date in August 2018, resident #041 personal care and registered staff #101 was assisting PSW #110 to facilitate the provision of care. The resident fell and sustained an injury. Interview with PSW #110, confirmed that staff did not use safe transferring and positioning devices or techniques when they failed to provide the required level of assistance when providing care to resident #041.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 1 as it was isolated. The home had a level 4 compliance history as there was ongoing noncompliance in the last 36 months with a CO under the same section May 25, 2017 and May 27, 2016. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 01, 2019(A1)

Order # / Ordre no : 005 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

(A1) The licensee must be compliant with O. Reg. 79/10, r. 50(2).
Specifically the licensee must:
1. Ensure residents #041, #072, #200 and all other residents when exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff using a clinically appropriate

assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.
2. Develop, implement and document an auditing process to ensure that resident #041, #072, #200 and all other residents exhibiting altered skin integrity, have a skin assessment completed by a member of the registered staff.
3. Retrain staff #101 and all other staff who failed to complete skin assessments when altered skin integrity was identified.

(A1) **Grounds / Motifs :**

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Critical incident (CI) report #2779-000020-18 submitted to the MOHLTC in relation to an alleged incident of improper care on an identified date in August 2018, was reviewed. The clinical record of resident #041 including the progress notes was reviewed. Resident #041 fell on an identified date in August 2018. As a result, the resident sustained injury. As confirmed with the DOC, a skin assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

2. During the inspection, resident #072 complained to the Inspector that whenever they required personal care between identified hours they were put at risk for skin breakdown.

The clinical record of resident #072 was reviewed including the progress notes and care plan. Progress note documentation of an identified date in May 2018, indicated there was an area of altered skin integrity which the staff treated. The early morning documentation of an identified date in July 2018, indicated the resident reported to the staff they were uncomfortable and treatment was applied. That evening the area of altered skin integrity was observed and the area was washed and a treatment was applied. Progress note documentation on the following day indicated the area on the resident was noted to be worsening in condition. The area was cleaned and treatment was applied.

There was no documentation found in the resident's record of a skin assessment completed for the area of altered skin integrity identified on the identified date in July 2018, by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound

assessment. Registered staff #123 reviewed the clinical record of resident #072 and confirmed there was no assessment of the altered skin integrity on the resident.

Registered staff #123 reported the resident had a history of altered skin integrity which would resolve and return. The registered nursing staff who documented concerning the altered skin integrity confirmed they should have completed a skin assessment and initiated a Treatment Administration Record (TAR) and then the area should have been assessed weekly. Registered staff #123 reviewed the clinical record of resident #072 and confirmed the altered skin integrity on resident #072 was not assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. (123)

3. On an identified date in September 2018, the ADOC verified that the expectation was that all areas of altered skin integrity would be recorded in the resident's clinical record in Point Click Care (PCC), assessment tab, under wound assessments when the area of altered skin integrity was discovered.

A review of the clinical record for resident #200 identified that the resident had an area of altered skin integrity. A review of the clinical record did not include an assessment of the area of altered skin integrity using a clinically appropriate assessment. On an identified date in August 2018, it was documented that the resident had multiple areas of altered skin integrity. The clinically appropriate assessment was initiated but only discussed the measurements of one of the four areas identified. On an identified date in September 2018, the ADOC confirmed that the resident did not have an assessment of all the identified areas of altered skin integrity completed, as required when the areas were first identified using a clinically appropriate assessment instrument. (506)

The non-compliance was issued as a CO. The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 2 as it was a pattern. The home had a level 4 compliance history with ongoing non-compliance in the last 36 months with a CO issued February 13, 2018 with a compliance due date of April 1, 2018; a CO issued May 24, 2017 and a VPC issued November 25, 2015 under the same section. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 15, 2019(A1)

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 : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

(A1)
The licensee must be compliant with O. Reg. 79/10, r. 131 (2).

Specifically the licensee must:
1. Ensure that resident #070, #071, #081, #082 and all other residents with identified medications have the drug administered in accordance with the directions for use specified by the prescriber.
2. Develop, implement and document auditing process to ensure that resident #070, #071, #081, #082 and all other residents with identified medications have the drugs administered in accordance with the directions for use specified by the prescriber.
3. Provide retraining to registered staff #116, #158, #161, #147, #101, #142, #124 and #160 and all other registered staff who administer identified medications to residents.
4. Provide retraining on reporting of missing identified medications for registered staff #147 and #101.

Grounds / Motifs :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) A review of the home's medication incidents for the second quarter was completed. This review included an Incident Report for an identified date in May, 2018, regarding a scheduled medication which was not administered to resident #071.

The Incident Report identified that resident #071 did not receive a scheduled dose of medication on an identified date in May, 2018, at an identified time as prescribed by their physician. The medication was found in its dated and timed package in the locked medication cart seven and a half hours later. At this time it was noted by staff #123 that the medication remained in its package.

A review of the clinical record identified that resident #071 was monitored for identified symptoms, after the error was identified. As documented in the progress notes resident #071 was experiencing identified symptoms on this date. The resident received an as needed (PRN) dosage of an analgesic medication at 1700 hours with good effect as documented in the electronic Medication Administration Record.

A review of the May 2018, electronic Medication Administration Record (eMAR) identified that a signature was not in place on the identified date and time in May, 2018, as required, to identify that the medication was given.

Interview with registered staff #123, identified that they found the medication in the medication cart at the end of their shift on the same date. Registered staff #123 reported that they completed the incident reports and notified the physician. They also reported that the resident received PRN analgesic medication along with increased monitoring after the incident.

Interview with the Resident Assessment Instrument (RAI) Coordinator #131, identified that based on their internal investigation, resident #071, on the identified date and time, did not receive their medication as prescribed.

Drugs were not administered to resident #071 in accordance with the directions for use specified by the prescriber. (674)

B) A review of the home's medication incidents for the second quarter was completed. This review included an Incident Report, for an identified date in May, 2018 regarding scheduled medications which were not administered to resident #070.

The Incident Report identified that resident #070 did not receive scheduled dosages of two medications on an identified date in May, 2018 at an identified time as

prescribed by their physician. The medications were found in their dated and timed package in the medication cart the following day. A review of the incident report identified that the resident did not have any indication of harm as a result of the incident. The clinical record of resident #070 was reviewed including the progress notes and assessments documented that the resident did not have any adverse reactions as a result of the missed medications.

Interview with registered staff #116 identified that they found the medications in the medication package. They reported that they completed the incident reports and assessed the resident.

Interview with the RAI Coordinator #131 identified that based on their internal investigation, resident #070, did not receive their prescribed medication.

Drugs were not administered to resident #070 in accordance with the directions for use specified by the prescriber. (674)

C) Critical incident (CI) report #2779-000027-17 was submitted to the MOHLTC on an identified date in October, 2017, in relation to two of resident #082's identified medications missing.

The clinical record for resident #082 was reviewed including the progress notes. A medication progress note dated for an identified date in October, 2017, at an identified time stated that the PSW had informed them that the medication was not administered during morning care. A progress note indicated that the resident was due to have their medication that shift. Registered staff #158 attempted to administer the medication but identified it missing from the medication cart.

Interview with registered staff #158 reported that on the identified date in October, 2017, they reported the missing medication to the DOC who reported the concern to the pharmacist.

D) Resident #082 had a physician's order dated for an identified date in September, 2017, for a medication.

During interview with registered staff #147, they indicated that resident #082 had missing medication, however, they were unable to recall whether resident #082 was

due for medication or if it had been administered earlier. During the inspection, it was noted on the "Monitored Medication Record" that the medication was administered on the evening of an identified date in October, 2017, twenty four hours earlier. Registered staff #147 stated they administered another medication when it was found missing according to their progress note which was 5.25 hours after shift change the last time the medication was identified as present.
Interview with registered staff #147 reported, that the missing medication was not reported to the DOC.

The home's records including the "Shift Change Monitored Medication Count" from identified dates in October, 2017 to January, 2018, were reviewed. It was noted that on an identified date in October, 2017, the count which had been completed by two registered staff, stated that resident #082 did not have a medication administered. Registered staff #101 reported that they were unable to locate the medication so another one was administered. They also reported that the missing medication was not reported to the DOC. The "Monitored Medication Record" was reviewed. It was noted that a medication was administered on the evening of an identified date in October, 2017, twenty four hours earlier.

The home failed to ensure that resident #082's medication was administered to the resident in accordance with the directions for use specified by the prescriber. (536)

E) Critical incident (CI) report #2779-000030-17 submitted to the MOHLTC on an identified date in December, 2017 in relation to two of resident #081's identified medications missing.

The clinical record for resident #081 was reviewed including the progress notes. The physician's order indicated that resident #081 was to be administered a medication.

The home's records including the "Monitored Medication Record" were reviewed. The record indicated that medication was administered on an identified date in December, 2017, to resident #081's by registered staff #122.

A review of the progress notes written for an identified date in December, 2017, indicated that registered staff #142 and two other staff were unable to locate the resident's medication at that time. PRN analgesic medication would be offered for pain management until a new medication was administered or the previous

medication was located.

Progress notes of an identified date in December, 2017, indicated that registered staff #142 was not able to locate the medication as prescribed and a new medication was administered to the resident.

The home failed to ensure that resident #081's medications were administered to the resident in accordance with the directions for use specified by the prescriber. (536)

The non-compliance was issued as a CO. The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 3 as it was a widespread. The home had a level 4 history as there was ongoing non-compliance with a CO under the same section August 15, 2017, May 24, 2017 and a VPC May 27, 2016 and November 26, 2015. (536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 15, 2019(A1)

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, r. 71 (3).

Specifically the licensee must:
1. Ensure that residents #002, #073, #074, #090, #091, #092, #093, #094, #097 and #098 and all other residents are offered a minimum of three meals daily.
2. Ensure that residents #053, #054, #055, #056, #057, #075 and all other residents are offered a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and a snack in the afternoon and evening.
3. Develop, implement and document an auditing process to ensure that all residents including those not able to be in the dining room are offered three meals daily and to ensure that all residents are offered a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and a snack in the afternoon and evening.

Grounds / Motifs :

1. The licensee failed to ensure that each resident was offered a minimum of three meals daily.

A) An observation of the meal service was completed in identified dining rooms on an identified date in July, 2018. It was noted that a number of residents were absent

from the dining room for the meal service. Inspector #583 was present until the end of the dining service at which time it was observed food was removed from the servery and no trays were prepared for room service.

After the service was completed interviews were conducted with RPN #142 and #126, as well as with PSW's #143, #134 and #144 who were all present for the meal service. Through observations and interviews with the staff it was confirmed that residents #073, #074, #090, #091, #092, #093, #094 and #097 were not present in the dining room for the meal and were not offered a meal tray. Resident #073, #074, #090, #094 and #097 were all assessed as being at an identified nutrition risk.

Interview with RPN's #126 and #142, reported that the homes’ expectation was that meals were to be provided in the dining room, there was not typically a meal tray service for residents and no enhanced snacks or special dietary interventions were in place for missed meals. In interviews completed with registered nursing staff and PSW's, it was reported that not all residents were brought to the dining room for meal service on all units on a regular basis and tray service was not usually provided.

The “Dietary” care plan interventions were reviewed for all the residents noted above and none identified that it was part of their plan of care not to receive the meal nor were any dietary interventions in place for missed meals.

The “Daily Assignment Sheet” was reviewed and it was confirmed with the Employee Services Coordinator, that there were no staff shortages in the home on the identified date. (583)

B) A complaint was received by MOHLTC on an identified date in June, 2018, alleging that residents were not receiving three meals per day. An observation of the lunch meal service was completed in the home area dining room on an identified date in July, 2018. Residents #073 and #002 were not present for the meal service and meal trays were not made up and offered to them at the end of the service.

At the end of meal service, Inspector #674 noted resident #073 and #002 were in bed. Interview with PSW #134 at 1345 hours by Inspector #674 confirmed that both residents were not offered a meal tray.

Interviews completed with registered nursing staff and PSW's on an identified date in

July, 2018, confirmed that not all residents in the home were offered three meals per day. (583)

C) A complaint was received by MOHLTC alleging that resident #098 was not provided a meal on an identified date in August, 2018. A review of the clinical record confirmed resident #098 was only offered two meals on that date. An interview with the DOC/Acting Administrator confirmed that resident #098 was not provided three meals per day .(506)

2. The licensee failed to ensure that each resident was offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and (c) a snack in the afternoon and evening.

A) On two identified dates in July, 2018, inspector #156 identified residents of a home area were not being offered a minimum of a, between-meal beverage in the morning and a beverage and snack in the evening after dinner. This information was confirmed by PSW #111, #112 and #117 and was brought to the attention of the management at that time. (156)

B) Seven days later, inspector #583, identified ongoing concerns related to residents on the home area not being offered a between meal beverage in the morning and a between meal beverage and snack in the afternoon and evening. This was confirmed by interview of PSW staff working on the home area and the Food Services Manager (FSM).

C) The following week, the non-compliance was again identified by inspector #123 as the residents of a home area had not received a between meal beverage in the morning. This was confirmed during interviews with PSW staff and the DOC. The DOC indicated to the inspector that the afternoon and evening beverages and snacks would be provided to the residents.

D) On an identified date in August, 2018, PSW staff on a home area informed inspector #674 that residents of that home area were not offered a between-meal beverage that morning. The corporate staff #128 also confirmed residents of another home area were not provided a between-meal beverage in the morning of an identified date in August, 2018.

E) The following day, the home submitted CI report #2779-000018-18 to the MOHLTC which was reviewed. It was noted that on an identified date in August, 2018, the management noticed that not all residents were in the dining room for breakfast. When the staff were questioned they reported that due to staff shortages they were not able to get all residents up for breakfast. Staff were instructed to get all residents up. Staff reported the residents were in bed because they did not have time to provide care to them. The management inquired about the nourishment cart and whether between-meal beverages were being provided to residents. Staff informed the management staff that they did not do that and explained the staff had been told they were exempted from the snack cart for 12 weeks by the former DOC and former Administrator. (123)

PSWs, registered staff the DOC, ADOC and corporate staff #128 confirmed the residents were not offered a between-meal beverage in the morning as indicated above.

F) A review of the July 2018, POC documentation related to morning nourishment of the residents noted in CI report #2779-000019-18 indicated:

i) Resident #053 received morning nourishments 16% of the time. Not applicable (which meant that the resident did not receive the nourishment) was documented 48% of the time and no documentation with blank spaces observed on the remaining days.

ii) Resident #054 received morning nourishments 6% of the time. Not applicable was noted 54% of the time and no documentation with blank spaces observed 39% of the time.

iii) Resident #055 received morning nourishments 10% of the time. Not applicable was noted 32% of the time and no documentation with blank spaces observed 58% of the time.

iv) Resident #056 received morning nourishments 10% of the time. It was noted as not applicable 58% of the time and no documentation with blank spaces observed 32% of the time.

v) Resident #057 received morning nourishments 3% of the time It was noted as not

applicable 56% of the time; noted as resident refused 6% of the time; resident not available 3% of the time and no documentation with blank spaces observed 9% of the time.

vi) Resident #075 received morning nourishments 10% of the time. It was noted as not applicable 51% of the time; resident refused 3% of the time and no documentation with blank spaces observed 35% of the time.

The licensee failed to ensure that each resident was offered a between-meal beverage in the morning, afternoon and evening after dinner; and a snack in the afternoon and evening. (123) [s. 71. (3)]

The non-compliance was issued as a CO. The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 3 as it was widespread. The home had a level 2 compliance history as there was one or more unrelated non-compliance in the last 36 months. (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2019

Order # / Ordre no : 008 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically the licensee must:
A) Ensure that residents #004, #101, #103 and all other residents are protected from abuse by anyone.
B) Ensure that residents #002, #004, #007, #015, #053, #054, #055, #056, #057, #060, #062, #072, #073, #074, #075, #098, #101, #102, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #156 and all other residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. 1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The O. Reg 79/10, s. 2 (1) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident 's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

The O. Reg 79/10, s. 2 (1) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are preformed by anyone other than a resident.

Critical incident (CI) report #2779-000008-18 submitted to the MOHLTC in relation to an alleged abuse incident of an identified date in April, 2018, was reviewed. The clinical record of resident #004 including the progress notes were reviewed. Progress note documentation of May, 2018, indicated the resident reported to staff that an identified person made a threat of retaliation in relation to an alleged abuse incident. Progress notes for an identified date in May, 2018, indicated the resident reported to the staff that another identified person had made an abusive comment in relation to the same incident. The resident was noted to have been emotionally upset by these occurrences.

Social worker records noted that resident #004 was involved in an incident which increased their emotional symptoms.

The DOC/Acting Administrator confirmed resident #004 was not protected from verbal and emotional abuse.

The review of resident #004's progress notes indicated that on an identified date in August, 2018, the resident reported to the registered staff an allegation of potential abuse. The registered staff was noted to have provided support to resident #004 and stated they would speak to the DOC the following day.

The Assistant Director of Care (ADOC) and Corporate staff #128 were interviewed and reported potential abuse. The resident was upset by the interaction. The alleged interaction met the home's definition of emotional abuse. The home notified the police of the allegation of abuse.

The home did not protect resident #004 from verbal and emotional abuse.

2. The licensee failed to ensure that residents were protected from abuse by anyone and to ensure that residents were free from neglect by the licensee or staff.

O. Reg. 79/10 s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Critical Incident (CI) report #2779-000025-18 submitted to the MOHLTC on an identified date in August, 2018, was reviewed. It indicated that on that date, resident #095 was involved in an incident with resident #103 athat resulted in injury. The

police were notified of the incident. The home's investigative records and the residents' clinical records were reviewed. Resident #103 confirmed the incident occurred as noted above. The DOC was interviewed and confirmed the accuracy of the information as documented in the CI report.

The home did not ensure that resident #103 was protected from physical abuse by resident #095.

3. The licensee failed to ensure that residents were protected from abuse by anyone and ensured that residents were not neglected by the licensee or staff.

O. Reg. 79/10 s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Critical Incident report #2779-000022-18 submitted by the home to the MOHLTC on an identified date in August, 2018, was reviewed. It indicated that on that date, resident #095 was involved in an incident with resident #101 that resulted in injury. The residents' clinical records and the home's investigative records were reviewed and indicated information as contained in the CI report. The DOC confirmed the accuracy of the information in the CI report.

The home did not ensure that resident #101 was protected from physical abuse by resident #095.

4. The licensee failed to ensure that residents were not neglected by the licensee or staff.

According to O. Reg. 79/10, s. 5 neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents.

1) Resident's did not receive assistance with toileting and/or continence care as required:

A) Resident #072 who required assistance with toileting was not provided care to manage their incontinence between identified times during the meal service. As a

result, the resident was incontinent and was identified with a skin breakdown. Registered staff #123 reported the resident had a history of ongoing altered skin integrity which would resolve and return. Registered staff #123 confirmed that resident #072 had incontinence and required the assistance of staff as per the plan of care. They confirmed when resident #072 was incontinent between the identified hours, they were not provided the required assistance to maintain their continence.

B) On an identified date in July, 2018, resident #060 was observed by the inspector with signs of incontinence. The resident was observed again an hour and a half later where it was noted the resident still had signs of incontinence. A review of the clinical record related to continence care confirmed that the staff were to check resident #060 provided specified assistance prior to meals and after meals. An hour and a quarter later, the resident was again observed and it was noted that the resident still exhibited signs of incontinence. Interview with RPN #106 confirmed that the resident was to be checked prior to meals and after meals and confirmed resident #060 was incontinent. PSW #105 confirmed resident #060 was not provided specified care prior to or after their meal as directed by their care plan.

C) On an identified date in August, 2018, the Inspector observed resident #098 for approximately three hours. During this time, the resident was not provided specified care. A review of the resident's plan of care under the PSW's tasks confirmed that the resident was to be checked every two hours. During Interview with PSW #109, they confirmed that they last checked the resident at an identified time and were aware that the resident's plan of care directed them to check every two hours. They also confirmed that resident #060 was not checked every two hours.

2) Residents were not bathed.

A) In an interview with resident #156 on an identified date in July, 2018, they reported they did not receive a bath on an identified date in July, 2018 and confirmed they were not offered a rescheduled bath.

B) In an interview with PSW #144 on an identified date in July, 2018, it was reported that residents who had baths scheduled on identified home areas on two identified dates in July, 2018, during the 0600 to 1200 hour shifts did not receive baths as well as the residents who had their baths scheduled on another identified date in July, 2018, during the 1300 to 2100 hour shift.

C) A review of the Point of Care (POC) documentation for an identified week in July, 2018 identified the following:

i) On an identified date in July, 2018, there was no documentation found to indicate that resident #101, #102's and #104's scheduled baths were completed or offered and there was no documentation indicating their baths were rescheduled.
ii) On another identified date in July, 2018, there was no documentation found to indicate that residents #007, #105, #106, #107 and #004's scheduled baths were completed or offered and there was no documentation indicating their baths were rescheduled. It was documented identified residents received a bed bath instead of their preferred choice.
iii) On another identified date in July, 2018, there was no documentation that residents #108, #062, #109, #110, #111, #112, #113 and #114's scheduled baths were completed or offered and there was no documentation indicating their baths were rescheduled.
Through completion of interviews with residents and staff, reviews of Point of Care POC documentation and reviews of staff shortages identified on the daily assignment sheets it was confirmed that each resident in the home was not being bathed a minimum of twice per week. (583)

D) The plan of care for resident #057, indicated that they required assistance with bathing and referred to a "Bathing List" for frequency and specific dates. The resident confirmed that they preferred to have a bath on specific days and times of the week, but on certain days, they did not receive a bath on their preferred days. The resident stated that they received a bath on an identified date in September, 2018, but no other baths for two weeks prior. (120)

E) CI report #2779-000019-18 submitted to the MOHLTC was reviewed. The clinical records including the care plans, progress notes and the May, June and July 2018, POC documentation of residents #053, #054, #055, #056, #057 and #075 were reviewed. All residents were noted to require the assistance of two staff for transfers and one staff for bathing.

The review of the May 2018, POC documentation indicated:
i) Resident #053 received five baths and not applicable was indicated six times.
ii) Resident #055 received seven baths and not applicable two times.

iii) Resident #075 received six baths; refused one bath and not applicable was noted four times.
The review of June 2018, POC documentation indicated:
i) Resident #053 received six baths and not was noted not applicable seven times;
ii) Resident #054 received four baths; refused two baths; not applicable noted for one bath; not available for one bath and no documentation with blank space observed for one bath;
iii) Resident #055 received five baths and not applicable noted two times;
iv) Resident #057 received three baths; refused three baths and not applicable once and
v) Resident #075 received four baths and not applicable was noted four times.
The review of the July 2018, POC documentation indicated:
i) Resident #053 received seven baths; not applicable four times;
ii) Resident #054 received six baths and not applicable was noted three times;
iii) Resident #055 received five baths and not applicable five times;
iv) Resident #056 received seven baths and not applicable once and
v) Resident #076 received six baths and not applicable was noted two times.

Interview with PSWs and the DOC confirmed each resident of the home did not receive bathing a minimum of twice per week. The licensee failed to ensure that residents were not neglected in relation to bathing.

The MOHLTC received complaints #018920-18; # 018387-18; #018113-18 and #016094-18 regarding the lack of care for the residents. The complaints were reviewed and the complainants were interviewed. They reported information as contained in the complaints.

3) Residents were not offered three meals daily.

A) An observation of meal service was completed in identified home area dining rooms on an identified date in July, 2018. It was noted that resident #073, #074, #090, #091, #092, #093, #094 and #097 were not present in the dining room for the meal and were not offered a meal tray.

RPN's #126 and #142 were interviewed and they reported that the homes’ expectation was that meals were to be provided in the dining room, tray service was not provided for residents for missed meals. In interviews with registered nursing

staff and PSW's it was reported that, on a regular basis, not all residents were brought to the dining room for meal service on all home areas. (583)

B) The meal service was observed in a home area on an identified date in July, 2018. Residents #073 and #002 were not present for the meal service and meal trays were not made up or available for them at the end of the service.
At the end of lunch service Inspector #674 noted resident #073 and #002 were in bed. Interview with PSW #134 by Inspector #674 confirmed that both residents were not offered a meal tray. (583)

C) A complaint was received by MOHLTC on an identified date in August, 2018 alleging that resident #098 was not provided an identified meal on an identified date in August, 2018. A review of the resident's clinical record confirmed resident #098 was only offered two meals on the identified date. An interview with the DOC/Acting Administrator confirmed that resident #098 was not provided three meals daily.

The licensee failed to ensure that residents were not neglected by the licensee or staff in relation to the provision of three meals daily.

4) Residents were not dressed/groomed:

A) The Substitute Decision Maker (SDM) of resident #015 reported that the resident was not always dressed appropriately for the time of day.
The clinical record of resident #015 was reviewed. Progress note documentation indicated that on an identified date in June, 2018, the SDM complained that resident #015 was not dressed in their own clothing, appropriate to the time of day. The SDM requested that the resident be dressed prior to the bath unless the bath was at an identified time or immediately after. A note was placed in the communication book to inform staff. The resident's plan of care was reviewed and it did not include any of the above information as requested by the resident's SDM. The DOC confirmed the above information was not included in the resident's plan of care.

B) A complaint received by MOHLTC identified that a visitor was in to see resident #074 on an identified date in June, 2018, and the resident was still in bed at 1100 hours and staff were asked to assist the resident with personal care. On an identified date in July, 2018, resident #074 was observed in bed and was not assisted to the dining room for breakfast. The progress notes for July, 2018, were reviewed and it

was noted on an identified number of occasions that the resident had no intake at breakfast. In addition, POC documentation under the “what percentage of the meal was eaten”? section during a 30 day look back period dated August, 2018, indicated that resident #074 was 'not available' for an identified number of meals. PSW staff reported that they documented 'not available' when residents were not in the dining room for meals and tray service was not provided.

The licensee failed to ensure that residents were not neglected by the licensee or staff in relation to dressing and grooming.

5) Residents were not provided nourishments.

PSW staff reported that they were instructed that for a twelve week period beginning in May 2018 they were exempt from doing the nourishment carts. Residents were not offered between-meal beverages in the morning and afternoon and a beverage in the evening after dinner; and snacks in the afternoon and evening.

Nourishments were not provided as confirmed by the DOC, corporate staff #128, the ADOC as well as noted in CI report#2779-000019-18.

A) In July, 2018, inspector #156 identified residents of a home area were not being offered a minimum of a, between-meal beverage in the morning and a beverage and snack in the evening after dinner. This information was confirmed by PSW #111, #112 and #117 and was brought to the attention of the management on an identified date in July, 2018. (156)

B) On an identified date in July, 2018, inspector #583, identified ongoing concerns related to residents on another home area not being offered a between meal beverage in the morning and a between meal beverage and snack in the afternoon and evening. This was confirmed by interview of PSW staff working on the home area and the Food Services Manager (FSM).

C) On an identified date in August, 2018, the non-compliance was again identified by inspector #123 as the residents on an identified floor had not received a between meal beverage in the morning. This was confirmed during interview with the DOC.

D) On an identified date in August, 2018, PSW staff on a home area informed

inspector #674 that residents of that home area were not offered a between-meal beverage that morning. The corporate staff #128 also confirmed residents on an identified floor were not provided a between-meal beverage in the morning that day.

E) On an identified date in August, 2018, the home submitted CI report #2779-000018-18 to the MOHLTC which was reviewed. It was noted that on an identified date in August, 2018, the management noticed that not all residents were in the dining room for breakfast. Staff reported the residents were in bed because they did not have time to provide care to them. The management staff inquired about the nourishment cart and whether that was being provided to residents. Staff informed the management staff that they did not do that and explained the staff had been exempted from the snack cart for 12 weeks. (123)

PSWs, registered staff the DOC, ADOC and corporate staff #128 confirmed the residents were not offered a between-meal beverage in the morning as indicated above.

F) A review of the July 2018, Point of Care (POC) documentation related to morning nourishment of the residents noted in CI report #2779-000019-18 indicated:
i) Resident #053 received morning nourishments five days. Not applicable was documented on 15 days and no documentation with blank spaces observed on the remaining 11 days;
ii) Resident #054 received morning nourishments on two days. Not applicable was noted on 17 days and no documentation with blank spaces was observed on 12 days;
iii) Resident #055 received morning nourishments on three days. Not applicable was noted on 10 days and no documentation with blank spaces was observed on 18 days;
iv) Resident #056 received morning nourishments on three days. It was noted as not applicable on 18 days and no documentation with blank spaces observed on 10 days;
v) Resident #057 received morning nourishments on one day. It was noted as not applicable on 17days; noted as resident refused on two days; resident not available on one day and no documentation with blank spaces was observed on nine days and
vi) Resident #075 received morning nourishments on three days. It was noted as not applicable on 16 days; resident refused on one day and no documentation with blank spaces observed on 11 days. (123) [s. 71. (3)] (156)

The licensee failed to ensure that residents were not neglected by the licensee or staff in relation to the provision of nourishments.

The licensee failed to ensure that the residents were not neglected by the licensee or staff. [s. 19. (1)]

The non-compliance was issued as a CO. The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 2 as it was a pattern. The home had a level 3 history as there was one or more related non-compliance in the last 36 months with a WN under the same section on May 26, 2017. (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 15, 2019(A1)

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 11st day of April, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by MELODY GRAY (123) - (A1)

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