Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 29, 2021	2021_886630_0027 (A1)	006391-21, 011143-21, 012807-21, 013850-21	Critical Incident System

Licensee/Titulaire de permis

The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's
643 West Gore Street Stratford ON N5A 1L4

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

Spruce Lodge Home for the Aged
643 West Gore Street Stratford ON N5A 1L4

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

Amended by AMIE GIBBS-WARD (630) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Licensee has requested an amendment to allow further time to ensure compliance. The compliance due date for Compliance Order (CO) #004 related to LTCHA s. 23. (1) is being changed from October 8, 2021, to October 31, 2021.

Issued on this 29th day of September, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by AMIE GIBBS-WARD (630) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 3, 4, 5, 6, 9, 10, 11, 12, 13, 23, 24, 25, 26, 27, 30, 31, September 1, 2 and 3, 2021.

The following Critical Incident (CI) intakes were completed within this inspection:

Related to falls prevention and management:

Log #006391-21 / CI M575-000004-21

Related to the prevention of abuse and neglect:

Log #011143-21 / CI M575-000006-21

Log #012807-21 / CI M575-000007-21

Log #013850-21 / CI M575-000008-21

An Infection Prevention and Control (IPAC) as well as Cooling Requirements and Air Temperature inspection was also completed.

Inspectors Loma Puckerin (#705241) and Alicia Marlatt (#590) were also present for this inspection.

NOTE: Written Notifications (WN) and Compliance Orders (CO) related to LTCHA, s. 6(7), s. 20(1) and s. 23(1) as well as WNs and Voluntary Plans of Correction (VPC) related to LTCHA, s. 24(1) and s. 76(4) were identified in a concurrent inspection #2021_886630_0027, and issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Environmental Services Manager, the Nutrition Services Manager, the Registered Dietitian (RD), the Infection Prevention and Control (IPAC) Program Lead, the COVID-19 screener, an external Human Resources (HR) Consultant, an external nursing agency Operations Manager, the Scheduling Clerk, Registered Nurses/Team Leads (RNs), Registered Practical Nurses (RPNs), Housekeepers, Personal Support Workers/Resident Assistants (PSWs), a Dietary Aide/Student, family members and residents.

The inspectors also observed resident rooms and common areas, observed meal and snack service, observed IPAC practices within the home, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed COVID-19 Directive #3 and Directive #5 for Long-Term Care Homes as well as reviewed the home's written staffing plan, written letters of complaint and relevant policies/procedures of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

17 WN(s)
9 VPC(s)
8 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure the written plan of care set out clear directions to staff.

i) A resident had concerns about the care provided to them by staff in the home. The resident's plan of care did not provide clear direction for staff, which placed them at risk for not receiving the continence care they required.

ii) Staff reported one of the residents tended to have responsive behaviours when they were being provided personal care. Staff said the resident would be given as needed (PRN) medications to help manage these behaviours. The resident's medication record showed they had PRN medications ordered, however none of these included directions for use. The resident's plan of care and medication orders did not provide clear direction for staff regarding the use of the PRN medications. The lack of clear direction placed the resident at risk for not receiving the care they required.

iii) Based on observations and interviews, a resident regularly refused care and medications from staff. The plan of care for the resident did not include clear direction for staff regarding their refusal of care or regular medication refusals. This placed the resident at risk for not receiving the care or medications they required.

Sources: Interview with a resident and their family member; a Critical Incident System report; a written letter of complaint to the home; residents' clinical records including plan of care; interviews with a Registered Practical Nurse (RPN) and

other staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care for residents was provided to them as specified in the plan.

i) During multiple observations a resident was found sleeping in their bed with their bed in a position different than what was specified in their plan of care. Staff said they thought this resident's bed was to be in that position. The Assistant Director of Care (ADOC) was shown pictures of the positioning of the resident's bed, and they said it should not be in that position as it was a safety risk for the resident. The ADOC said they thought the home's new Environmental Service Supervisor would be looking into the safety concerns about the positioning of the resident's bed.

ii) Multiple staff reported safety concerns to Inspector #630 that resident bed alarms were not consistently on and/or functioning properly. A resident's plan of care included a bed alarm attached to the call response system, due to a risk of falls. During the inspection this resident had a sensor pad on their bed, but there were no cords connecting it to an alarm or the call response system. A staff member said the bed alarm had not been functioning properly for a few weeks and this had been reported to the registered nursing staff. The resident's progress notes showed the bed alarm was not functioning properly and there was no further documentation showing this had been resolved until 23 days later. The resident had an unwitnessed fall and their bed alarm was noted to be on but not functioning properly at the time. The lack of consistent provision of a functioning bed alarm, as per the plan of care, placed this resident at risk for injuries from falls.

iii) A resident was having responsive behaviours and was refusing the assistance being provided by staff. The staff did not follow the interventions in the resident's plan of care when responding to the resident's responsive behaviours care needs. The resident was not physically harmed during this incident, however there was risk to the resident's emotional well-being related to the staff's actions at the time.

iv) A resident was observed to have been provided their prescribed 0800 hour medications two hours after the specified time. The registered nursing staff said the morning medication administration scheduled for residents at 0800 hours was difficult to complete before 1000 hours most days. They said their morning medication pass covered three resident areas and around 47 residents and the

orders for most residents were specified as 0800 hours. The DOC said the home had identified concerns with timely administration of medications due to the large number of residents with 0800 hour medications, as well as some residents who required extra time and reapproach. The Director of Care (DOC) said this resident's medications were not administered in accordance with their plan of care as they should have been given within one hour of the ordered time. They said the concern about late medication administration had been brought forward to the management and they were looking at increasing the staffing levels in the home. This resident was at risk for not receiving the care they required for responsive behaviours due to not receiving their medications at the prescribed time.

Sources: Observations August 31 and September 2, 2021; residents' clinical records including eMARs; a CIS report; interview with an anonymous complainant; interviews with the DOC and other staff. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with by staff and management.

i) The home submitted a CIS report related to allegations of staff to resident neglect. The home's written Zero Tolerance of Abuse and Neglect policy defined neglect to include the failure to provide the care set out in a resident's plan of care or provide assistance to residents when required. Based on interviews with staff and a review of the home's investigation, there were multiple parts of the policy which were not complied with related to reporting and investigating this alleged neglect. The lack of compliance with the home's policy placed residents at risk of harm as the alleged neglect was not immediately and fully investigated.

ii) The home's prevention of abuse and neglect policy stated all employees were required to immediately report alleged, suspected or witnessed abusive acts to the most senior supervisor in resident care department at the time of the incident. A person expressed allegations of abuse and improper care to an inspector, reporting that the concerns and incidents were an accumulation of witnessed incidents involving an identified staff member over a period of time. They confirmed they had been trained to immediately report any witnessed, suspected or alleged abuse when they started at the home. They said they had wanted to wait to report the concerns and had not intervened when the alleged incidents actually happened.

Sources: The home's "Zero Tolerance of Abuse and Neglect" policy revised June 2018; a CIS report; an external consultant's investigation report; email communications; an interview with an external consultant; and interviews with staff. [s. 20. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by staff, that the licensee knew of or was reported, was immediately investigated and appropriate action taken in response to every such incident.

i) Multiple staff reported to Inspectors #630 and #590 that they had concerns for residents' well being on the night shift as they were not receiving the care they required, which they considered neglect. Staff said they had reported concerns of resident neglect on the night shift to the registered nursing staff and the management in the home either verbally or through an email. These allegations were not immediately investigated, as the initial concerns had been communicated more than four months prior to the start of the home's investigation. The management in the home did not conduct interviews with staff as part of the investigation, as this had been solely the role of an external consultant. The external investigator’s interviews started nine days after the management in the home identified that an investigation was needed. Some relevant staff were not interviewed as part of this investigation. The external investigator told Inspector #630 that staff were reluctant to tell them names of

residents who had been affected by the alleged neglect, as they were concerned about confidentiality. There were no residents who had been interviewed as part of the investigation. The DOC said the allegations were related to neglect of residents in all areas of the home on night shift and it was difficult to identify specific residents who had been affected. The lack of an immediate investigation into the alleged neglect, including investigations and assessments of individual residents affected by the alleged neglect in the home, placed residents at risk of harm.

ii) The home's prevention of abuse and neglect policy stated that the home had a responsibility to investigate alleged abuse as soon as they became aware of any alleged resident abuse. Further, that any employees, or other service providers who were alleged to have abused a resident would be interviewed by the involved RN or Manager in order to investigate the reported incident. A person reported to the management that they witnessed what they believed was staff to resident abuse. The allegations of abuse was not immediately investigated.

Sources: The home's Zero Tolerance of Abuse and Neglect policy revised June 2018; a CIS report; an external consultants investigation report; email communications; an interview with an external consultant; and interviews with the DOC and other staff. [s. 23. (1)]

Additional Required Actions:

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

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements.

The home's "Mandatory Indicator Tracking Form" for 2021 showed an average of 52 missed resident baths per month including 62 in February, 41 in July and 42 in August. Staff reported bathing care was affected by the staffing levels in the home as vacant bath shifts were not consistently filled or resident baths made up if missed at the scheduled time. The DOC said the number of missed baths had gone down over the year as they had introduced a bath line, however there were times when they were unable to fill the bathing shifts. The DOC said the expectation in the home was that every resident would be provided two baths per week of their preference, either shower or tub, which were to last 30-40 minutes. The DOC said a bed bath was only to be used in exceptional circumstances. They said it was the expectation if a bath was refused the staff would reapproach at another time. Based on interviews and record reviews during the inspection, three specific residents were not provided their required bathing care.

Sources: Interview with a resident and their family member; a CIS report; written letter of complaint to the home from a resident's family member; residents' clinical records including Documentation Survey Reports for February, July and August 2021; the home's Mandatory Indicator Tracking Form 2021; interviews with a PSW and other staff. [s. 33. (1)]

Additional Required Actions:

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

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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was exhibiting altered skin integrity they 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.

A progress note showed a PSW had reported that a resident had an open skin area. There was no documented assessment of this reported altered skin integrity

by a member of the registered nursing staff until 19 days later. It was the expectation in the home that any area of altered skin integrity would be reported by the PSWs and then an assessment completed and documented by the registered nursing staff. The lack of a timely skin assessment did not result in harm to the resident, but did place them at risk for not receiving required skin care.

Sources: The resident's clinical records including Skin/Ulcer Assessments; interviews with a Registered Nurse (RN) and other staff. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that two residents, who were exhibiting altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff.

i) A resident had an open skin area which required weekly reassessments by the registered nursing staff. There was no documented re-assessment completed for a 13 day period. The resident said they had no concerns with the skin and wound care in the home. The missing assessment did not cause harm to the resident, however the missing assessment placed them at risk.

ii) Another resident had areas of altered skin integrity which required weekly reassessments by the registered nursing staff. There were no documented re-assessments for a 14 day period. The re-assessments that were completed for two of the areas did not include all the required details. The Wound Care Lead acknowledged that some of the resident's weekly assessments had been missed and said it could have been times when staff did not have time to complete the assessments. They said overall the resident's skin had been healing well but still required weekly assessments to be completed. The lack of weekly skin assessments did not result in harm to the resident, but did place them at risk for not receiving required skin care.

Sources: A CIS report; the residents' clinical records including Skin/Ulcer Assessments; interviews with the Wound Care Lead RN and other staff. [s. 50. (2) (b) (iv)]

3. The licensee has failed to ensure that residents who were dependent on staff for repositioning, were repositioned every two hours or more frequently as required.

During the home's investigation into an allegation of resident neglect, it was identified to management that staff had concerns that residents were not receiving adequate care on the night shift. Staff told Inspector #630 that they had concerns that two specific residents were not consistently turned and repositioned and they had compromised skin integrity. The residents' assessments and plans of care showed they required extensive assistance from two staff with turning and repositioning and they were at risk for skin breakdown. The documentation of care for the residents showed repositioning care had not been completed on each night shift. The DOC said based on the home's investigation into alleged neglect, residents had not consistently received care as per the home's expectations for the night shift including three purposeful rounds for turning and repositioning. The lack of turning and repositioning care placed the residents at risk for skin breakdown.

During the home's investigation into another incident it was identified that a resident had not been turned and repositioned as required during a specific evening and night shift. During an interview with a staff member, they said they had not been in the practice of turning or repositioning this resident during their night shifts, as this was not something they had been trained to do and thought it was not part of the resident's plan of care. The resident's clinical record showed they had compromised skin integrity and needed assistance with turning and repositioning in bed.

Sources: CIS reports; residents' plans of care and other clinical records; interviews with the Assistant Director of Care (ADOC) and other staff. [s. 50. (2) (d)]

Additional Required Actions:

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

WN #6: 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 has failed to ensure that residents who required continence care products, had sufficient changes to remain clean, dry and comfortable.

The home's investigations into two separate alleged incidents of staff to resident neglect or improper care on night shifts, found residents were not receiving adequate continence care. Based on interviews with staff and clinical record reviews three specific residents, who required assistance from staff for continence care product changes, were not provided with the care they required to remain clean and dry. The lack of consistent continence care placed the residents at risk for skin breakdown and discomfort.

Sources: Residents' plans of care and other clinical records; Critical Incident System (CIS) reports; the home’s investigation documentation; and interviews with staff. [s. 51. (2) (g)]

Additional Required Actions:

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

WN #7: 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,
(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. The licensee has failed to ensure that procedures were implemented for the cleaning and disinfection of supplies and devices, including personal assistance services devices (PASDs).

The home's policy and shift routines outlined specific processes for cleaning of resident care equipment, which identified that wheelchairs and walkers were cleaned nightly. Staff said wheelchair cleaning was to be done on the night shift, was a weekly task and was to be documented in Point of Care (POC).

A staff member reported concerns that residents' wheelchairs and walkers were not being cleaned regularly, which they felt was due to short staffing on night shift. The inspectors observed several residents using wheelchairs and walkers that appeared dirty. A review of three residents' POC documentation showed their equipment had not been cleaned weekly.

Sources: Observations; the clinical records for three residents; the home’s written policy “Cleaning, Servicing & Repairing Resident Care Equipment – Guidelines’, last revised October 2006; RA (Resident Assistant) Shift Routine Guidelines 23:00 -07:00 (Night) Shift Lodge; interviews with staff. [s. 87. (2) (b)]

Additional Required Actions:

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

WN #8: 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 has failed to ensure the shift routines, included in the required Nursing and Personal Support Services program, were complied with consistently on the night shift between February and July 2021.

LTCHA s.8 (1)(b) requires an organized program of personal support services for the home to meet the assessed needs of residents. This section defines personal support services as “services to assist with the activities of daily living, including personal hygiene services, and includes supervision in carrying out those activities.”

O. Reg. 79/10, 31 (3) (b) requires the written staffing plan for this program to set out the organization and scheduling of staff shifts.

Specifically, staff did not comply with the home’s procedure "Resident Assistant (RA) Shift Routine Guidelines 2300 to 0700 (Night Shift) Lodge", dated February 27, 2020 and June 2021. This routine required staff to complete purposeful rounding for visual checks and attending to resident’s needs with the goal of hourly rounds as well as at least three rounds of continence/toileting/turning during the night.

Multiple staff reported concerns to the management in the home about care provided to residents on the night shifts. The home's investigation determined specific staff in the home had not been complying with the home's expected night care routines. The DOC said staff were expected to follow the shift routines and they had been working to provide further education to the night shift staff regarding these expectations and requirements.

Sources: A Critical Incident System (CIS) report; RA Shift Routine Guidelines 2300-0700 (Night) Shift Lodge February 2020 and June 2021; an External Consultant's investigation report; interviews with the DOC and other staff. [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 the shift routines, included in the required Nursing and Personal Support Services program, are complied with consistently on the night shift, to be implemented voluntarily.

WN #9: 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).

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a

resident, were kept closed and locked.

During multiple observations, Inspector #630 found there was a door that lead to a non-secure outside area that was not fully closed or locked. Staff indicated that the door needed to be pulled tight to ensure it was closed and locked, and at times this was not done properly. On the door there was a sign which stated "please make sure this East Wing door going in or out is locked at all times there has been a resident who exit seeks. This door if left open would be ideal for the resident to get outdoors if left unlocked."

The home's Internal Security policy stated "doors leading to stairways and to the outside are locked at all times, and are equipped with door access control system that is on at all times." The DOC and Administrator said it was the expectation in the home that doors leading to non-secure outside areas were to be kept locked at all times. The door not being consistently locked placed residents at risk for elopement or unsupervised access to outside spaces.

Sources: Observations August 9, 11 and 12, 2021; interviews with staff; and the home's "Internal Security" policy updated January 2018. [s. 9. (1) 1.]

2. The licensee has failed to ensure there was a written policy that dealt with doors leading to secure outside areas regarding when they were to be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

Observations on August 9, 2021, found all the doors leading to the Centre Courtyard, Cottage A Courtyard and Cottage B & C Courtyard were not locked. Observations on August 10 and 13, 2021, found all the doors leading to the Centre Courtyard and the Cottage A Courtyard were not locked.

There was a notice posted for staff on August 10, 2021, which stated "this week may hit temperatures of 40 degrees, and humidity will be high." This notice did not include direction related to resident access to the secure outside spaces.

During interviews with management and staff it was identified that the home did not have a written policy that dealt with doors leading to secure outside areas. The home's "Internal Security" policy identified that doors leading to outside were to be locked at all times, and did not include any further directions related to doors leading to secure outside areas. The staff and management said they thought the doors leading to the secure outside areas could be unlocked to allow residents to

access the spaces during nice weather. The was no specific process in the home for supervising or monitoring residents who were going out the doors to the secure areas. The lack of a written policy placed residents in the home at risk related to unsupervised access to outside spaces.

Sources: Interviews with staff; observations August 9, 10 and 13, 2021; a resident's progress notes and other clinical records; a Critical Incident System (CIS) report; and the home's "Internal Security" policy updated January 2018. [s. 9. (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 all doors leading to 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, are kept closed and locked; and to ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident cooling equipment, specifically portable fans, were kept clean and sanitary.

During the inspection there were nine portable fans in dining and resident rooms in three different areas of the home with dust build-up on the blades and/or cover. Staff and residents reported that the fans were used when the air temperature in the home was too warm. The Environmental Services Manager (ESM) said the resident fans were not included in specific cleaning or job routines. They said it was up to the staff to identify fans that were not clean and then put in a work order for the maintenance staff to disassemble and clean the fans. The ESM said they were not sure the last time these portable fans in resident areas had been cleaned.

The home's Infection Prevention and Control Program (IPAC) Lead indicated that the expectation in the home was for portable fans to be kept clean and these fans did not meet the expectations for cleanliness in the home. The IPAC lead indicated they were familiar with the Public Health Ontario recommendations that during COVID-19 portable fans required routine cleaning to help minimize potential risk of infection transmission.

The Administrator was shown pictures of some of the observed fans and said it did not meet the expectations of the home related to cleanliness. They said the home recently hired a new Environmental Services Supervisor who will be looking into deep cleaning of the fans in the home.

The home's lack of consistent cleaning and disinfecting practices for portable fans placed residents at risk.

Sources: Observations August 3, 4, 5 and 25, 2021; interviews with residents; Ontario Agency for Health Protection and Promotion (Public Health Ontario). At a glance – the use of portable fans and portable air conditioning units during COVID-19 in long-term care and retirement homes, 2020; and interviews with the ESM and other staff. [s. 15. (2) (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 resident cooling equipment is kept clean and sanitary, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that air temperatures were documented in writing at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night in at least two resident bedrooms in different parts of the home and one resident common area on every floor of the home.

The home had central air conditioning throughout the resident hallways and common areas. There was a process in place for the Environmental Services Manager (ESM) and maintenance staff to check and document the air temperatures in two resident rooms and eight common areas of the home three times per day. A review of the "Air Temperature Audit" forms found incomplete documentation. The ESM said they were aware of the legislative requirements and was not sure why there was a delay in the implementation of the temperature documentation or the reason for the missing documentation.

There was no identified harm to residents related to this lack of documented temperature monitoring.

Sources: Observations August 3, 2021; "Air Temperature Audit" forms July and August 2021; interview with the ESM. [s. 21. (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 air temperatures are documented in writing at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night in at least two resident bedrooms in different parts of the home and one resident common area on every floor of the home, to be implemented voluntarily.

WN #12: 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in risk of harm or neglect of a resident by staff that resulted in harm or risk of harm had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

There were two separate allegations of staff to resident abuse or neglect that were reported to the management in the home which were not immediately reported to the Ministry of Long-Term Care (MLTC) through the after-hours line or the Critical Incident System (CIS). In one instance the CIS report was made three days late and did not include all of the grounds the management of home was aware of regarding the alleged improper care of residents.

Sources: Interviews with the Assistant Director of Care (ADOC) and other staff; the home's "Zero Tolerance of Abuse and Neglect" policy last revised June 2018; and three Critical Incident System (CIS) reports. [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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately reports 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. 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., to be implemented voluntarily.

WN #13: 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 has failed to ensure the home's staffing plan, including the back-up plan for nursing and personal support services, provided for a staffing mix that was consistent with residents' assessed care and safety needs.

During the inspection multiple staff expressed concerns to the inspectors regarding the staffing levels in the home not meeting the care needs of the residents. It was reported that the home usually did not have the full complement of PSW and registered nursing staff and the staff felt it had gotten worse over the past year.

Two residents told Inspector #630 that they had to wait for care from staff at times as the staff were busy helping other residents.

During a night shift, Inspector #630 observed there were two PSWs for 71 residents in the Lodge area from 0300 to 0630 hours, as the third PSW had left at 0300 as they had been working overtime from the previous evening shift. Throughout the night shift the PSWs were constantly moving, and at times running, from room to room to respond to call bells, complete rounds and provide continence care. The staff said they were trying their best to meet the care needs of the residents but felt rushed in the care they were providing.

The management in the home reported there had been unfilled shifts due to staff call-ins and staff who were on leave. The home's indicator tracking showed 41 "short staff shifts" in June, 47 in July and 51 in August. Despite the home's written contingency plan for filling vacant shifts and adjusting the provision of care to residents, these shifts were not filled and care was not consistently provided to the residents as needed. The DOC said the home tended to be short one to two PSW shifts per day.

During the course of the inspection, care concerns were identified with timely medication administration, bathing care, the completion of skin assessments, turning and repositioning, continence care and the cleaning of residents' wheelchairs and walkers on the night shift, as have been documented in other areas of this report.

The DOC and Administrator reported they had reviewed the home's staffing plan regularly and they were planning to make changes based on the budget and funding to help ensure resident care was being provided as needed. The DOC said it had been identified that the staffing levels on night shifts would be better able to meet the resident care needs with seven PSW staff versus the current six per shift. They said they had added a new bathing shift within the past year due to concerns that bathing care not being provided as required, however at times they were unable to fill those shifts as the PSWs were pulled to work in resident care areas. The DOC also said they were looking to increase the number of RPN shifts due to concerns with timely medication administration.

The home's written staffing plan did not consistently meet the care needs of the residents in the home between January and August 2021, which placed the residents at risk.

Sources: Observations; the home's "Mandatory Tracking Form 2021"; the home's written staffing plan, shift routines and staffing contingency plan; interviews with

residents; interviews with staff. [s. 31. (3)]

2. The licensee has failed to ensure a written record was kept relating to the annual evaluation of the written staffing plan required under O. Reg. 79/10, s. 31 (3) (e).

The Administrator and DOC said the home's practice was to review the staffing plan in the fall each year as part of the annual budgeting process. They said the most recent review had started in September 2020, and was ongoing since then through the Resident First Committee and other leadership meetings. They said during the COVID-19 pandemic there had been some changes implemented to the staffing plan to include Resident Services Assistants (RSAs). The DOC said they were looking at making changes to the staffing plan such as the number of PSW staff on night shift, staffing for mealtime care and RPN staffing levels. The Administrator said their staffing plan and review was usually based on the funding provided by the Ministry of Long-Term Care (MLTC) and had not changed a lot in the past few years.

They said the home did not use or have a written record for the documentation of the annual review of the staffing plan. The Administrator said the Resident First Committee minutes had documented discussions in June, July and August 2021 regarding the staffing plan and there may have been other meeting minutes that contained discussions of changes to the staffing plan. The minutes reviewed did not include the date of the evaluation, the names of the person who had participated in the evaluation, the summary of changes made or the date the changes had been implemented.

Sources: Interviews with the Administrator and DOC; the Resident First Committee minutes June, July and August 2021. [s. 31. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the staffing plan provides 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; and to ensure there is a written record of the annual evaluation and updates to the staffing plan 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, to be implemented voluntarily.

WN #14: 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. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff received retraining annually related to the following: the Residents' Bill of Rights; the home's policy to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and whistle-blowing protections.

The home's prevention of abuse and neglect policy included annual mandatory training as part of the home's abuse prevention strategies. A review of the homes educational records for the year 2020 and 2021 year thus far, showed that of an identified 239 staff members only 214 had completed their annual required training, which was 89% of staff. In interviews with two staff they both stated that it had been awhile since they had done any training on abuse and neglect and could not recall if they had completed it within the last year.

Sources: LTCH's educational records, interviews with Human Resources (HR), the Director of Care (DOC) and other staff members; the home's 'Zero Tolerance of Abuse and Neglect' policy last revised June 2018. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #15: 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. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and the resident's substitute decision-maker, if any, were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC), which included allegations of neglect towards seven identified residents. The Director of Care (DOC) said the home had completed the investigation into staff to resident neglect and the management in the home. They said they had not contacted the residents or their family members with the results of the home's investigation. The home's Zero Tolerance of Abuse and Neglect policy stated that the residents and/or substitute decision makers (SDMs) were to be notified of the investigation results immediately on completion of the investigation.

Sources: The home's "Zero Tolerance of Abuse and Neglect" policy revised June 2018; a CIS report; and an interview with the DOC. [s. 97. (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 resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included the required information for two written complaints they had received.

The home's "Complaints" policy stated "all verbal or written complaints are recorded in a Spruce Lodge Complaints form and directed to the respective Manager or Administrator." The Administrator and Director of Care (DOC) said they were no longer following the process as directed in the policy, as they had developed a new electronic form. There was no documented electronic or written record which contained the required information for two complaints the home had received. There was no record of the dates the complaints were received, the dates of the actions taken to resolve the complaints or the dates and description of the responses to the complainants.

Sources: Interviews residents and family members; interviews with the DOC and Administrator; the home's "Complaints" policy dated September 2017; the DOC's investigation documentation; and Critical Incident System (CIS) report. [s. 101. (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 a documented record is kept in the home related to the complaints that includes the (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The license has failed to immediately forward to the Director a written complaint concerning the care of a resident.

A resident told Inspector #630 that their family member had written a letter of complaint to the home about concerns with their care. The Director of Care (DOC) said they had received a complaint letter from this family member and acknowledged it was not immediately forwarded to the Ministry of Long-Term Care (MLTC).

Sources: Interview with a resident and their family member; interviews with the DOC and Administrator; and the home's "Complaints" policy dated September 2017. [s. 22. (1)]

Issued on this 29th day of September, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMIE GIBBS-WARD (630) - (A1)
Inspection No. / No de l'inspection :	2021_886630_0027 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	006391-21, 011143-21, 012807-21, 013850-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 29, 2021(A1)
Licensee / Titulaire de permis :	The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's 643 West Gore Street, Stratford, ON, N5A-1L4
LTC Home / Foyer de SLD :	Spruce Lodge Home for the Aged 643 West Gore Street, Stratford, ON, N5A-1L4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Peter Bolland

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with s. 6 (1) of the LTCHA.

Specifically, the licensee must:

- Review and revise the written plan of care for a resident to ensure it sets out clear directions to staff regarding their as needed (PRN) medication administration for responsive behaviours.

- Review and revise the written plan of care for a resident, in consultation with the resident and their designated family member, to ensure it sets out clear directions to staff regarding bowel continence care.

- Review and revise the written plan of care for a resident to ensure it sets out clear directions to staff regarding interventions for their responsive behaviours related to refusal of care and medication administration.

Grounds / Motifs :

1. The licensee has failed to ensure the written plan of care set out clear directions to staff.

i) A resident had concerns about the care provided to them by staff in the home. The resident's plan of care did not provide clear direction for staff, which placed them at

risk for not receiving the continence care they required.

ii) Staff reported one of the residents tended to have responsive behaviours when they were being provided personal care. Staff said the resident would be given as needed (PRN) medications to help manage these behaviours. The resident's medication record showed they had PRN medications ordered, however none of these included directions for use. The resident's plan of care and medication orders did not provide clear direction for staff regarding the use of the PRN medications. The lack of clear direction placed the resident at risk for not receiving the care they required.

iii) Based on observations and interviews, a resident regularly refused care and medications from staff. The plan of care for the resident did not include clear direction for staff regarding their refusal of care or regular medication refusals. This placed the resident at risk for not receiving the care or medications they required.

Sources: Interview with a resident and their family member; a Critical Incident System report; a written letter of complaint to the home; residents' clinical records including plan of care; interviews with a Registered Practical Nurse (RPN) and other staff. [s. 6. (1) (c)]

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

Severity: There was risk of harm because residents were more likely to not receive the care they required related to the lack of clear direction in their plan of care.

Scope: Two of the three residents reviewed for responsive behaviours and one of the three residents reviewed for continence care did not have clear direction in their plan of care, demonstrating a pattern of non-compliance.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 6 (1) and one Voluntary Plan of Correction (VPC) issued to the home. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

- Ensure that the care set out in a resident's plan of care regarding the position of their bed for safety is provided to them as specified in the plan.

- Ensure that the care set out in a resident's plan of care regarding falls prevention is provided to them as specified in the plan. In addition, develop and implement a process to check the functionality of the resident's bed alarm, and all other resident bed alarms, on a regular basis. A documented record of this process must be maintained in the home.

- Ensure the responsive behaviour related interventions in a resident's plan of care are provided to them consistently by all staff as specified in the plan.

- Ensure the care set out in a resident's plan of care for the timing of medication administration is provided to them as specified in the plan. In addition, develop and implement a process to ensure a specific resident, and all other residents with 0800 hour medications in a specific area, receive their medications at the times specified in their prescribed orders. A documented record of this process must be maintained in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care for

residents was provided to them as specified in the plan.

i) During multiple observations a resident was found sleeping in their bed with their bed in a position different than what was specified in their plan of care. Staff said they thought this resident's bed was to be in that position. The Assistant Director of Care (ADOC) was shown pictures of the positioning of the resident's bed, and they said it should not be in that position as it was a safety risk for the resident. The ADOC said they thought the home's new Environmental Service Supervisor would be looking into the safety concerns about the positioning of the resident's bed.

ii) Multiple staff reported safety concerns to Inspector #630 that resident bed alarms were not consistently on and/or functioning properly. A resident's plan of care included a bed alarm attached to the call response system, due to a risk of falls. During the inspection this resident had a sensor pad on their bed, but there were no cords connecting it to an alarm or the call response system. A staff member said the bed alarm had not been functioning properly for a few weeks and this had been reported to the registered nursing staff. The resident's progress notes showed the bed alarm was not functioning properly and there was no further documentation showing this had been resolved until 23 days later. The resident had an unwitnessed fall and their bed alarm was noted to be on but not functioning properly at the time. The lack of consistent provision of a functioning bed alarm, as per the plan of care, placed this resident at risk for injuries from falls.

iii) A resident was having responsive behaviours and was refusing the assistance being provided by staff. The staff did not follow the interventions in the resident's plan of care when responding to the resident's responsive behaviours care needs. The resident was not physically harmed during this incident, however there was risk to the resident's emotional well-being related to the staff's actions at the time.

iv) A resident was observed to have been provided their prescribed 0800 hour medications two hours after the specified time. The registered nursing staff said the morning medication administration scheduled for residents at 0800 hours was difficult to complete before 1000 hours most days. They said their morning medication pass covered three resident areas and around 47 residents and the orders for most residents were specified as 0800 hours. The DOC said the home had identified concerns with timely administration of medications due to the large number of residents with 0800 hour medications, as well as some residents who required extra

time and reapproach. The Director of Care (DOC) said this resident's medications were not administered in accordance with their plan of care as they should have been given within one hour of the ordered time. They said the concern about late medication administration had been brought forward to the management and they were looking at increasing the staffing levels in the home. This resident was at risk for not receiving the care they required for responsive behaviours due to not receiving their medications at the prescribed time.

Sources: Observations August 31 and September 2, 2021; residents' clinical records including eMARs; a CIS report; interview with an anonymous complainant; interviews with the DOC and other staff. [s. 6. (7)]

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

Severity: There was risk of harm because residents #020, #006, #022 and #017 did not receive care as specified in their plan of care.

Scope: Two of the three residents reviewed for responsive behaviours and two of the three residents reviewed for bed safety had issues with staff non-compliance with their plan of care, demonstrating a pattern.

Compliance History: Three written notifications (WN), nine voluntary plans of correction (VPCs) and two Compliance Orders (CO) were issued to the home related to different sections of the legislation in the past 36 months. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 10, 2021

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the LTCHA.

Specifically, all staff and management of the home's must be re-trained on the written policy to promote zero tolerance of abuse and neglect to ensure they have a working understanding of the requirements for reporting and investigating staff to resident neglect. A record of this retraining must be kept in the home.

Ensure that any time an investigation into alleged resident abuse and neglect involves an external consultant, the home's written policy to promote zero tolerance of abuse and neglect is complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with by staff and management.

i) The home submitted a CIS report related to allegations of staff to resident neglect. The home's written Zero Tolerance of Abuse and Neglect policy defined neglect to include the failure to provide the care set out in a resident's plan of care or provide assistance to residents when required. Based on interviews with staff and a review of the home's investigation, there were multiple parts of the policy which were not complied with related to reporting and investigating this alleged neglect. The lack of compliance with the home's policy placed residents at risk of harm as the alleged

neglect was not immediately and fully investigated.

ii) The home's prevention of abuse and neglect policy stated all employees were required to immediately report alleged, suspected or witnessed abusive acts to the most senior supervisor in resident care department at the time of the incident. A person expressed allegations of abuse and improper care to an inspector, reporting that the concerns and incidents were an accumulation of witnessed incidents involving an identified staff member over a period of time. They confirmed they had been trained to immediately report any witnessed, suspected or alleged abuse when they started at the home. They said they had wanted to wait to report the concerns and had not intervened when the alleged incidents actually happened.

Sources: The home's "Zero Tolerance of Abuse and Neglect" policy revised June 2018; a CIS report; an external consultant's investigation report; email communications; an interview with an external consultant; and interviews with staff. [s. 20. (1)]

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

Severity: There was risk of harm because allegations of improper care and resident neglect were not reported and investigated in accordance with the home's policy.

Scope: Two of the three incidents of alleged improper care or neglect reviewed in this inspection found non-compliance with the home's policy zero tolerance of abuse and neglect policy, demonstrating a pattern.

Compliance History: Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 20(1) and one voluntary plan of correction (VPC) was issued to the home. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2021

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(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. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee must be compliant with s. 23 (1) of the LTCHA.

Specifically, immediately investigate allegations that two specific staff were neglecting and providing improper care to residents on the night shifts. This must include the identification and assessment of any specific residents in the home who had been affected by the alleged neglect.

Ensure any new allegations of staff to resident neglect are immediately investigated. This must include the identification and assessment of any specific residents in the home who had been affected by the alleged neglect.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by staff, that the licensee knew of or was reported, was immediately investigated and appropriate action taken in response to every such

incident.

i) Multiple staff reported to Inspectors #630 and #590 that they had concerns for residents' well being on the night shift as they were not receiving the care they required, which they considered neglect. Staff said they had reported concerns of resident neglect on the night shift to the registered nursing staff and the management in the home either verbally or through an email. These allegations were not immediately investigated, as the initial concerns had been communicated more than four months prior to the start of the home's investigation. The management in the home did not conduct interviews with staff as part of the investigation, as this had been solely the role of an external consultant. The external investigator's interviews started nine days after the management in the home identified that an investigation was needed. Some relevant staff were not interviewed as part of this investigation. The external investigator told Inspector #630 that staff were reluctant to tell them names of residents who had been affected by the alleged neglect, as they were concerned about confidentiality. There were no residents who had been interviewed as part of the investigation. The DOC said the allegations were related to neglect of residents in all areas of the home on night shift and it was difficult to identify specific residents who had been affected. The lack of an immediate investigation into the alleged neglect, including investigations and assessments of individual residents affected by the alleged neglect in the home, placed residents at risk of harm.

ii) The home's prevention of abuse and neglect policy stated that the home had a responsibility to investigate alleged abuse as soon as they became aware of any alleged resident abuse. Further, that any employees, or other service providers who were alleged to have abused a resident would be interviewed by the involved RN or Manager in order to investigate the reported incident. A person reported to the management that they witnessed what they believed was staff to resident abuse. The allegations of abuse was not immediately investigated.

Sources: The home's Zero Tolerance of Abuse and Neglect policy revised June 2018; a CIS report; an external consultants investigation report; email communications; an interview with an external consultant; and interviews with the DOC and other staff. [s. 23. (1)]

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

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

Severity: There was risk of harm because allegations of improper care and neglect were not immediately and thoroughly investigated.

Scope: Two of the three incidents of alleged neglect or improper care reviewed in this inspection had non-compliance with the home's investigation, demonstrating a pattern.

Compliance History: Three written notifications (WN), nine voluntary plans of correction (VPCs) and two Compliance Orders (CO) were issued to the home related to different sections of the legislation in the past 36 months. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 31, 2021(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 005

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 subsection 33 (1) of O. Reg. 79/10.

Specifically, ensure that three specific residents, and every other resident in the home, is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements.

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

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements.

The home's "Mandatory Indicator Tracking Form" for 2021 showed an average of 52 missed resident baths per month including 62 in February, 41 in July and 42 in August. Staff reported bathing care was affected by the staffing levels in the home as vacant bath shifts were not consistently filled or resident baths made up if missed at the scheduled time. The DOC said the number of missed baths had gone down over the year as they had introduced a bath line, however there were times when they were unable to fill the bathing shifts. The DOC said the expectation in the home was that every resident would be provided two baths per week of their preference, either shower or tub, which were to last 30-40 minutes. The DOC said a bed bath was only to be used in exceptional circumstances. They said it was the expectation if a bath was refused the staff would reapproach at another time. Based on interviews and record reviews during the inspection, three specific residents were not provided their required bathing care.

Sources: Interview with a resident and their family member; a CIS report; written letter of complaint to the home from a resident's family member; residents' clinical records including Documentation Survey Reports for February, July and August 2021; the home's Mandatory Indicator Tracking Form 2021; interviews with a PSW and other staff. [s. 33. (1)]

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

Severity: There was risk of harm because residents did not receive their preferred bathing care twice per week.

Scope: Three of the three residents reviewed for bathing care had non-compliance, demonstrating a widespread issue.

Compliance History: Three written notifications (WN), nine voluntary plans of correction (VPCs) and two Compliance Orders (CO) were issued to the home related to different sections of the legislation in the past 36 months. (630)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 31, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 006

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 :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee must be compliant with subsection 50 (2) of O. Reg. 79/10.

Specifically, ensure that three specific residents, and all other residents in the home who are dependent on staff for repositioning, are repositioned in accordance with their individual plan of care.

The home must also develop and implement a process for documenting in PCC the turning and repositioning care provided to three specific residents on each shift, including the frequency it was provided.

Grounds / Motifs :

1. The licensee has failed to ensure that residents who were dependent on staff for repositioning, were repositioned every two hours or more frequently as required.

During the home's investigation into an allegation of resident neglect, it was identified to management that staff had concerns that residents were not receiving adequate care on the night shift. Staff told Inspector #630 that they had concerns that two specific residents were not consistently turned and repositioned and they had compromised skin integrity. The residents' assessments and plans of care showed they required extensive assistance from two staff with turning and repositioning and they were at risk for skin breakdown. The documentation of care for the residents showed repositioning care had not been completed on each night shift. The DOC said based on the home's investigation into alleged neglect, residents had not consistently received care as per the home's expectations for the night shift including three purposeful rounds for turning and repositioning. The lack of turning and repositioning care placed the residents at risk for skin breakdown.

During the home's investigation into another incident it was identified that a resident had not been turned and repositioned as required during a specific evening and night shift. During an interview with a staff member, they said they had not been in the practice of turning or repositioning this resident during their night shifts, as this was not something they had been trained to do and thought it was not part of the resident's plan of care. The resident's clinical record showed they had compromised skin integrity and needed assistance with turning and repositioning in bed.

Sources: CIS reports; residents' plans of care and other clinical records; interviews with the Assistant Director of Care (ADOC) and other staff. [s. 50. (2) (d)]

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

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

Severity: There was risk for skin breakdown because three residents did not receive the turning and repositioning care they required.

Scope: Three of the three residents reviewed for turning and repositioning had non-compliance, demonstrating a pattern.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10, s. 50 (2) and one voluntary plan of correction (VPC) was issued to the home. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 31, 2021

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

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 :

The licensee must be compliant with subsection 51 (2) of O. Reg. 79/10.

Specifically, ensure that two specific residents, and any other resident in the home, who are dependent on staff for changing their continence care products, have sufficient changes to remain clean, dry and comfortable.

The home must also develop and implement a process for monitoring the continence care provided to residents on the night shifts. A documented record of this monitoring must be kept in the home.

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

Grounds / Motifs :

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

The home's investigations into two separate alleged incidents of staff to resident neglect or improper care on night shifts, found residents were not receiving adequate continence care. Based on interviews with staff and clinical record reviews three specific residents, who required assistance from staff for continence care product changes, were not provided with the care they required to remain clean and dry. The lack of consistent continence care placed the residents at risk for skin breakdown and discomfort.

Sources: Residents' plans of care and other clinical records; Critical Incident System (CIS) reports; the home’s investigation documentation; and interviews with staff. [s. 51. (2) (g)]

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

Severity: There was risk of skin breakdown and discomfort because three residents did not receive the continence care they required.

Scope: Three of the three residents reviewed for continence care had non-compliance with the frequency of continence product changes, demonstrating a widespread issue.

Compliance History: Three written notifications (WN), nine voluntary plans of correction (VPCs) and two Compliance Orders (CO) were issued to the home related to different sections of the legislation in the past 36 months. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 31, 2021

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(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;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee must be compliant with subsection 87 (2) of O. Reg. 79/10.

Specifically, ensure the home's procedures are consistently implemented for the cleaning and disinfection of all residents' mobility devices, including two specific residents' wheelchairs and one specific resident's walker.

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

Grounds / Motifs :

1. The licensee has failed to ensure that procedures were implemented for the cleaning and disinfection of supplies and devices, including personal assistance services devices (PASDs).

The home's policy and shift routines outlined specific processes for cleaning of resident care equipment, which identified that wheelchairs and walkers were cleaned nightly. Staff said wheelchair cleaning was to be done on the night shift, was a weekly task and was to be documented in Point of Care (POC).

A staff member reported concerns that residents' wheelchairs and walkers were not being cleaned regularly, which they felt was due to short staffing on night shift. The inspectors observed several residents using wheelchairs and walkers that appeared dirty. A review of three residents' POC documentation showed their equipment had not been cleaned weekly.

Sources: Observations; the clinical records for three residents; the home’s written policy “Cleaning, Servicing & Repairing Resident Care Equipment – Guidelines’, last revised October 2006; RA (Resident Assistant) Shift Routine Guidelines 23:00-07:00 (Night) Shift Lodge; interviews with staff. [s. 87. (2) (b)]

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

Severity: There was risk of harm because residents did not have their wheelchairs and walkers cleaned and disinfected regularly.

Scope: Three of the three residents reviewed did not have weekly cleaning of their PASDs in August, demonstrating a widespread issue.

Compliance History: Three written notifications (WN), nine voluntary plans of correction (VPCs) and two Compliance Orders (CO) were issued to the home related to different sections of the legislation in the past 36 months. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 31, 2021

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 29th day of September, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by AMIE GIBBS-WARD (630) - (A1)

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