Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 16, 2019	2018_603194_0019	025783-18	Resident Quality Inspection

Licensee/Titulaire de permis

Trent Valley Lodge Limited
195 Bay Street TRENTON ON K8V 1H9

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

Trent Valley Lodge
195 Bay Street TRENTON ON K8V 1H9

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

CHANTAL LAFRENIERE (194), ADELFA ROBLES (723), CAROLINE TOMPKINS (166), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 1, 2, 3, 4, 5, 10, 11, 12, 15, 16, 17, 18, 22, 23, 24, 25, 2018

Logs #002012-18, related to outbreak, Log #002613-18, Log #023302-18, Log #023826-18, Log #024605-18, Log #025211-18, complaints related to staffing and provision of care, Log #004822-18, Log #007792-18, Log #007974-18, Log #016566-18, Log #019574-18, Log #023322-18, related to resident to resident abuse, Log #025054-18, for allegations of staff to resident neglect, Log #009616-18, Log #016585-18, related to resident fall.

Inspector Lynda Brown (#111) was also present each day of the inspection as a Certified Trainer while adhering inspector Adelfa Robles (723).

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), RAI Coordinator, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Administrative Assistant, Registered Dietitian (RD), Food Service Manager/Environmental Service Manager (FSM/ESM), Dietary Aide (DA), Staffing/Nursing Clerk, Hygienist (Mobile Dental Hygiene), Representative of Family and Resident Councils.

Inspectors completed a tour of the building and resident care areas. Observed infection control practices, medication administration process, dining services, provision of staff to resident care. Reviewed staffing records and back up staffing plans, clinical health records of identified residents, resident financial records, staffing educational records, relevant policies related to prevention of abuse, falls, responsive behaviour, skin and wound, continence and pain.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **18 WN(s)**
- **12 VPC(s)**
- **2 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #011 so that their assessments are integrated, consistent with and complement each other.

Related to Log #007792-18:

During review of the internal abuse investigation related to a Critical Incident Report (CIR) for resident to resident abuse on an identified date involving resident #005 and resident #011, it was noted that the safety checks for resident #011 had been discontinued.

The CIR described that resident #011 was witnessed by RPN #155 to be displaying an identified responsive behavior towards resident #005.

Review of the clinical health record indicated that resident #011 was admitted to the home with a history responsive behaviour and had been placed on 15 min safety checks.

Resident #011 ambulated in the home with one staff assistance at the time of the incident.

The plan of care for resident #011 indicated that the resident was on 15 min checks for an identified responsive behaviour.

Review of the progress notes indicated that a care conference was provided on an identified date, stating that the plan of care had been reviewed and remained current.

Review of the clinical health record for resident #011 indicated that the 15 min safety checks were discontinued on an identified date, by RPN #102.

During interview with Inspector #194, RPN #102 indicated that 15 minute safety checks were discontinued for resident #011 after discussion with the PSW's on shift and conversation with Clinical Care Co-ordinator (CCC) #159. RPN #102 indicated that the prevailing practice directed that when a change was made to the plan of care for residents, a "change in care plan" form was to be completed and submitted to the RAI coordinator. RPN #102 indicated that due to the length of time that has past since this incident, they were unable to recall if this was completed for resident #011. Review of the progress notes was completed for the period indicated and there was no evidence of documentation to support that any change related to safety checks, had occurred in regards to the resident's plan of care or that the POA had been notified.

During the review of the internal abuse investigation, Inspector #194 became aware that SDM for resident #011 had not been informed of the change in the plan of care related to the discontinuation of the 15 min safety checks, until CCC #159 contacted SDM to inform them of incident of abuse that occurred, involving resident #011.

During interview with Inspector #194, the DOC indicated that the results of the abuse investigation involving resident #011 and resident #005 concluded that staff did not follow the interventions in the plan of care related to 15 minute safety checks for resident #011 and ensuring that resident #005 was "not to be left in the vicinity of specified residents unsupervised by staff".

The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #011 so that their assessments were integrated, consistent and complemented each other. RPN #102 discontinued the 15 min safety checks for resident #011 and did not collaborate with staff

on other shifts, RAI coordinator, or family, to ensure the safety of resident #011 related to discontinuation of safety checks.(194)

Related to Log #009616-18:

A CIR was submitted to the Director, for an incident that caused injury to a resident for which the resident was taken to hospital and which results in a significant change in the resident's health status, that occurred on an identified date. The CIR indicated the following occurred:

The CIR indicated that resident #003 had been in their mobility device in a specified area. The resident appeared to try to get up without assistance and fell. The resident was identified as a safety risk and was on 30 minute checks, a fall prevention device was also in place to alert staff if resident #003 was attempting to transfer. At the time of discovery, the fall prevention device was activated. Resident #003 was assessed for injury by RN #117 there was no apparent physical injury but noted that the resident did complain of pain. The physician assessed the resident the following day and did not identify an injury, resident #003 continued to complain of pain in a specific area. Staff were to manage the symptom of pain and resident #003 remained on a specified intervention until one assessment was completed. Transfer status was changed for all transfers. On an identified date resident #003 was expressing pain, resident was transferred to hospital for assessment and required medical interventions.

A review of the clinical records for a period of nine days was completed by Inspector #623 and indicated that resident #003 was assessed post fall by RN #117. The resident was assessed the following day by the physician, who wrote an order indicating staff were to monitor symptoms until assessed by the physiotherapist. On an identified date, an assessment was completed by the physiotherapist. Recommendations were made that resident #003 was to have limitations to their mobility and transfer. The physician was to be notified if symptoms worsened. Documentation in the progress notes identified that resident #003 was experiencing pain daily, despite receiving pain management. There was no indication that the physician or the nurse practitioner were notified that resident #003 continued to have ongoing pain following assessment by PT.

On an identified date, during separate interviews with Inspector #623, RPN #101 and #128 indicated that during the nine day period, after resident #003 experienced a fall, the resident complained of pain daily despite receiving pain management. RPN #128 indicated that they did not notify the physician when resident #003 continued to

experience pain following the fall, until the transfer to hospital .

On an identified date, during an interview with Inspector #623, RN#103 indicated that the staff were asked to monitor resident #003 for pain. This should have been completed on a pain flow record or on a pain assessment, both are paper documents. RN #103 indicated that if resident #003 was identified as experiencing pain greater than 4/10 for 24-48 hours, the physician should have been notified. There is no indication that the physician was notified that resident #003 was experiencing ongoing pain after the fall as identified in the progress notes.

The licensee has failed to ensure that staff and others involved in the different aspects of care for resident #003, collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and compliment each other, when resident #003 experienced ongoing pain daily with no relief from the prescribed medications, for nine days, before the resident was sent to the hospital for further assessment.(623) [s. 6. (4) (a)]

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

During this Resident Quality Inspection (RQI), Four CIR and five complaints by separate individuals and resident family members related to concerns of resident care and risk to resident safety were submitted to the Director and inspected.

Related to Log #023826-18:

The Power of Attorney (POA) for resident #001, submitted a complaint indicating that on an identified date, when visiting they found resident #001, unattended, without a meal during a specified meal service.

Review of the licensee's investigation, interview with the POA and the Director of Care, indicated that when the resident's POA asked a Dietary Aide (DA), if resident #001 had received their meal, the response was no. The DA advised the POA, the staff were busy with other residents and would get to resident #001 when they were finished.

Review of resident #001 plan of care related to food and fluid intake, outlined specified interventions related to the requirement of assistance.

Review of the complaint letter and interview with resident #001's POA, indicated,that the POA witnessed co-residents pushing the call bell for assistance. When assistance did not come for an extended period of time, the co-residents remained in need of continence care, until the PSW staff were able to assist the residents.

PSW #158, indicated thirty-two residents reside in a specified home area. On an identified date, there were two PSWs, who were able to provide direct/total care to the residents working in this home area. The third PSW, assigned to this home area, was unable to provide direct resident care due to work restrictions. PSW #158, indicated, the two PSWs, were not able to provide toileting to those residents, who require two staff assist and/or the use of a mechanical device for transfers.The PSW indicated residents #041, 042, 043, 044, 045, and resident #046, were not provided continence care, as per the residents' plan of care.

Review of the plans of care related to continence for residents #041, 042, 043, 044, 045 and resident #046, indicated the six residents identified, required extensive assistance from two staff and the use of a mechanical device for continence care.

PSW #158, indicated resident #040, did not receive a scheduled bath on an identified date, as resident #040 requires extensive assistance and is designated as requiring two staff for bathing. Review of the Point of Care (POC) documentation did not provide evidence that resident #040 was provided with an alternate bath schedule date.

PSW #158, indicated that if the two PSW staff were required for resident care, there would not have been a PSW staff available to assist residents while two person care was being provided to other residents.

Review of resident #040's plan of care related to bathing, outlined specified interventions related to the requirement of assistance.

Related to Log #025211-18, with reference to Log #002613-18 and Log #024605-18:

On an identified date, the Power of Attorney (POA) for resident #047, submitted a complaint to the Director related to resident care and risk to resident safety.

Review of the complaint documentation and interview with the POA, indicated four PSWs were assigned to the specific home area. Two of those PSWs were not able to provide resident care due to work restrictions.

Of the thirty-two residents in this home area, the POA indicated approximately twenty of the residents required the assistance of two PSWs for transfers and toileting.

The POA indicated co-residents call bells were ringing for extended periods of time. The two PSWs, who were able to provide resident care were not able to respond within a reasonable time period as they were assisting co-residents.

Interview with PSW #120, indicated thirty-two residents resided in this home area, twenty-two residents of the thirty-two residents required the assistance of two PSW staff for care. PSW #120, did not provide resident names, however did indicate that residents were waiting for an extended period of time to have their call bells answered and toileting was delayed. The residents remained in need of toileting care, until PSW staff were able to attend to the residents. PSW #120 indicated that residents who require two staff assistance for bathing, where often not provided their preference for bathing.

During separate interviews, PSW #141 and #142, confirmed that residents, who require two PSWs for toileting, bathing and transferring were waiting for extended periods of time for assistance, remained in need of toileting care, were not provided their preferred bathing and were self- transferring, rather than waiting for staff to come an assist, when the home areas were not staffed as per the PSW staffing plan.

Related to Log #023302-18:

A complaint was received by the MOHLTC, indicating that the family member had concerns related to resident #013. The complaint and follow up telephone interview with Inspector #194 indicated that if the family was not present resident #013 would not be provided the assistance to have rest periods. The complaint also described an incident on an identified date when assistance for transferring was requested for resident #013 and not provided by the staff at the home.

Review of the plan of care for resident #013 was completed and indicated under sleep and rest that;
- Ensure resident #013 is offered the opportunity to lay down after lunch daily.

Inspector #194 reviewed the flow sheet for resident #013 related to rest and sleep, for a specified period. The flow sheet indicated that resident #013 was assisted for a rest period, as per the plan of care on eight occasions. The flow sheet for resident #013 for

another specified period, indicated that rest periods were provided on two occasions.

During interview with Inspector #194, PSW #132 and PSW #110 indicated that a specified unit was frequently working short. PSW's explained that resident care needs such as resident #013 being assisted for rest periods was often not completed.

The DOC reviewed the complaint letter received from a family member of resident #013. The complaint letter indicated that resident #013 was not assisted to bed and provided specified care. The result of the home's investigation into the allegations confirmed that specified care for resident #013 was not provided on the identified date.

PSW #146 indicated that there were two PSW staff on the floor at the time, the call bells were ringing, we were trying to answer them as best we could. PSW #146 indicated, I remember seeing resident #013's family member and saw the call bell ringing, I did not speak to family or provide any care to resident #013.

PSW #147 indicated, not being aware that resident #013 had returned with family. PSW #147 indicated working with PSW #146, it was only the two of us on the floor at the time. PSW #147 indicated that they were providing care to another resident, and trying to keep up with call bell situation. PSW #147 indicated as they were bringing co-resident to their room, they noticed the family member of resident #013 standing in doorway. PSW #147 stated that they addressed the family member and stating they would return when they completed the co-resident's care. PSW #147 indicated that staff did not get back to provide any care for resident #013.

The licensee has failed to ensure that care set out in the plans of care for residents, #001, 041, 042, 043, 044, 045, 046, 047 and resident #040 were provided as specified, specifically related to the assistance and monitoring of food and fluid intake, bathing, toileting, sleep/rest and bedtime care.

Related to Log #004822-18 and Log #007792-18:

Two CIR's, were submitted to the Director related to resident to resident abuse during a specified period, involving resident #009.

A CIR indicated that resident #009 was witnessed by staff (unidentified) involved in an identified responsive behavior towards resident #012.

Another CIR indicated that resident #009 was witnessed by PSW #153 involved in an identified responsive behavior towards resident #005.

Resident #009 is described in the plan of care as being cognitively impaired. Review of the plans of care for resident #009 related to responsive behaviour, for a specified period was completed and identified a number of interventions.

PSW #140, #147, #156 and #157 indicated that resident #009 was on 15 min checks and was to be separated from resident #005 and other specified residents. PSW #156 indicated that resident #009 could not be facing resident #005 in the common area, PSW #140 indicated resident #009 could be common area, if the resident was out of reach of other co-residents, as the resident would display an identified responsive behavior towards co-residents as they passed by. PSW #147 and #157 indicated that resident #009 was to be assisted by staff, to their room post meals.

Resident #009 was observed by Inspector #194 on an identified date in a common area with resident #005.

Resident #009 was observed by Inspector #194 on another identified date, in a common area, with co-resident #008.

The licensee failed to provide care as set out in the plan of care for resident #009. Resident #009 was observed by Inspector #194 on two separate occasions to be in common area with identified residents, without any barrier between the residents.(194)

Related to Log #007792-18, Log #007974-18, and Log #016566-18:

Three CIR's were submitted by the home for resident to resident abuse during the a specified period involving resident #005.

CIR indicated that resident #011 was witnessed by RPN #155 involved in an identified responsive behavior towards resident #005.

CIR indicated that an unidentified resident witnessed by family member, involved in an identified responsive behavior towards resident #005.

CIR indicated that resident #009 was witnessed by PSW #153 involved in an identified responsive behavior towards resident #005.

Resident #005 is described in the plan of care as, requiring extensive assistance by staff for all ADL's, totally dependent with eating and mobility. Resident #005 was high risk for falls and was on 30 minute checks.

Review of the plans of care for resident #005 related to ensuring that the resident was safe from inappropriate behaviours from co-residents indicated:

-Resident #005 was on 15 minute checks to ensure the resident was not involved in an identified responsive behaviour by co-residents. Resident #005 was not to be left in the vicinity of any specified co-residents, unsupervised by staff.

PSW #156 indicated that interventions for ensuring that resident #005 is kept safe from identified responsive behaviour included, placing resident #005 behind the nursing station. PSW #156 also indicated that when resident #005 was agitated and displaying an identified responsive behavior, the resident would be assisted back to their room and falls prevention device was put in place.

PSW #147 indicated that interventions for ensuring that resident #005 was not involved in identified responsive behaviour, included keeping resident #005 away from specified residents and position resident #005 at nursing station when able, to be observed by staff.

PSW #157 indicated that interventions for ensuring that resident #005 was not involved in identified responsive behaviour, included positioning resident behind the nursing station. PSW #157 indicated that if specified residents were in the common areas, staff would try and position resident #005 at the nursing station or place the resident in their room with the call bell. All PSW staff interviewed by Inspector #194 indicated that resident #005 was on 15 min safety checks.

Resident #005 was observed by Inspector #194 on an identified date in a common area with resident #009.

The licensee failed to ensure that care set out in the plan of care related to responsive behaviours for resident #009 and #005 were provided as specified.(194) [s. 6. (7)]

3. The licensee had failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's

care needs change or care set out in the plan is no longer necessary.

Resident #008 triggered through Minimum Data Set (MDS) during Stage one of RQI.

A review of resident #008's health record indicated, resident #008's initial MDS assessment was completed on admission and indicated that the resident had no behavioural symptoms. A quarterly MDS review was completed an identified period later and indicated that resident #008 had increased responsive behaviours

A review of resident #008's progress notes for an identified period, indicated that resident #008 exhibited responsive behaviours:
- on six separate occasions in one identified month.
- on five separate occasions in another identified month.
- on one occasion on the final month.
During a review of the current plan of care for resident #008, there were no responsive behaviors, no triggers or interventions to manage the responsive behaviours, identified for the resident.

PSW #127, indicated that resident #008 had responsive behaviours towards staff. The PSW indicated interventions included walking away and re-approaching the resident once resident #008 started to calm down. PSW #127 also identified triggers for the responsive behaviours. PSW #127 confirmed that the resident's care plan did not identify resident #008's responsive behaviours towards staff.

RPN #102, indicated that resident #008 had responsive behaviours. RPN #102 stated the triggers for the responsive behaviours included a specified behaviour The RPN indicated staff would distract the resident, by using specified interventions. RPN #102 confirmed that the resident's care plan did not identify resident #008's responsive behaviours, behavioural triggers, or interventions used to manage the responsive behaviours.

The RAI Coordinator (RN #103), indicated that resident #008's exhibited responsive behaviours. RN #103 also stated that the written plan of care should have been revised to include the responsive behaviours, as well as triggers and interventions that were identified in the Mobile Response Team's Collaborative Care plan.

The licensee had failed to ensure that resident #008's plan of care was reviewed and revised, when the resident's care needs changed, when the resident developed new

responsive behaviours. [s. 6. (10) (b)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During this Resident Quality Inspection (RQI), five complaints submitted by separate individuals and residents' family members were inspected.
These five complaints and interviews with the registered nursing staff and PSW staff indicated concerns that the provision of resident care and resident safety were being compromised as a result of staff not being replaced for sick calls and/or staff who are at work with specified work restrictions related to providing resident care.

During an interview with Inspector #194 and #166 , the DOC confirmed that the PSW staffing plan to accommodate residents in the home to be:
- 32 residents resided on a specific home area
- 38 resident resided on another specified home area
- 32 residents resided on another specified home area
- 14 PSW on a specified shift, 4 PSW on a specified resident home area, 5 PSW on another specified resident home area, 4 PSW on another specified resident home area and one float (to be assigned daily by registered staff)
- 11 PSW on another specified shift, 3 PSW on a specified resident home area, 4 PSW on another specified resident home area, 3 PSW on another specified resident home area and a float (to be assigned daily by registered staff)
- 6 PSW on another specified shift, 1 PSW on a specified resident home area, 2 PSW on another specified resident home area, 2 PSW on another specified resident home area and a float.

The DOC also indicated that PSWs on modified work restrictions were accommodated, but not backed filled. The DOC explained that PSWs identified with work restrictions, came to work and the float would pick up the duties that could not be completed by the PSW with work restrictions. There were currently a number PSW staff with work restrictions working in the home, not being replaced.

Review of the staffing schedule with Nursing/staffing clerk was completed by inspector #194 for a two month period, the review showed the following:
- During one identified month, there was a total of 64 PSW full shifts not staffed and 80.5 hours of PSW partial shifts not staffed.
- During another identified month, there were 32 PSW full shifts not staffed and 28.5 hours of PSW partial shift not staffed.

The DOC has indicated that a proposal to change the PSW staffing schedule was drafted and proposed to the union but no specific changes had been made.

Related to Log# 023826-18:

The Power of Attorney (POA) for resident #001, submitted a complaint indicating concern for the care and safety for resident #001.

Review of the licensee's investigation, interview with the Director of Care, and during an

interview with resident #001's POA, was completed. The POA observed resident #001 on an identified date during a specified meal time unattended without a meal. The POA asked a Dietary Aide (DA) if resident #001 had received their meal, the response was no. The DA advised the POA, staff were busy with other residents and would get to resident #001 when they were finished.

The POA, indicated on that same date, witnessing a number of other co-residents pushing the call bell and calling for assistance and when assistance did not come for an extended period of time, those residents remained in need of continence care, until the PSW staff were able to assist.

PSW #158, a full-time PSW staff in resident #001's home area was interviewed by Inspector #166. PSW #158, who was on duty, indicated thirty-two residents reside in this home area and there were two PSWs, who were able to provide direct/total care to the residents, the third PSW, assigned to this home area on that date was unable to provide direct resident care due to unspecified work restriction.

PSW #158 indicated that the PSWs were not able to return to the dining room to ensure resident #001 was supervised/assisted and had received meal, as the two PSWs were providing care to residents who required two staff assist.

PSW #158, indicated residents #041, 042, 043, 044, 045, and resident #046 were not provided continence care as these residents required extensive assistance from two staff and the use of a mechanical aid for continence care.

PSW #158, indicated resident #040, did not receive a scheduled bath, as resident #040 requires extensive assistance and is designated as requiring two staff for bathing. Review of the Point of Care (POC) documentation did not provide evidence that resident #040 was provided with an alternate bath schedule date.

PSW #158, indicated because two PSW staff were required to provide care /bathing/toileting to residents #041, 042, 043, 044, 045, 046 and resident #40, there would not have been another available PSW staff to assist any other resident while two person care was being provided.

Related to Log #002613-18, with reference to Log #024605-18 and Log #025211-18:

The Power of Attorney (POA) for resident #047, submitted a complaint to the Director

related to resident care and risk to resident safety.

Review of the complaint and during an interview with Inspector #166, resident #047's POA indicated, that on an identified date, four PSWs were assigned to a specific home area. Two of those PSWs were not able to provide resident care due to unspecified work limitations. The POA indicated on the identified date, resident #047, waited approximately 20 minutes to be transferred from the bathroom, as there was only one PSW available to assist and resident #047 requires two person assist for transfer/toileting.

The POA also indicated, that on seven separate dates, residents' call bells were ringing for extended periods of time. The two PSWs, who were able to provide resident care were not able to respond within a reasonable time period as they were with other residents who required two person assist with care.

PSW #120, indicated thirty-two residents resided in a specific home area, twenty-two residents required the assistance of two PSW staff for care.

PSW #120, did not provide resident names, however did indicate that residents were waiting for extended periods of time to have their call bells answered, toileting care was delayed, residents remained in need of continence care until PSW staff were able to attend to those residents. The residents who required two staff assist for bathing, were not provided their preference for bathing.

On an identified date, separate interviews with PSW #141 and #142, confirmed that residents, who required two PSWs for toileting, bathing, transferring were waiting for extended periods of time for assistance, remained in need of continence care, were not provided their preference for bathing and are self-transferring rather than waiting for staff to come and assist, creating a potential safety risk related to falls.

Log # 23302-18 related to resident #013:

During interview with family member of resident #013, Inspector #194 was informed that a formal letter of complaint was submitted to the home related to care and transfer needs for resident #013 not being provided on an identified date. Review of the internal investigation into the concern verified that the home unit was not staffed as per the PSW staffing plan on the identified date. The PSW staff were unable to respond to the resident #013's call bell and family request to assist resident with care. Family member indicated

resident #013 was not provided specified care.

During separate interview with Inspector #194, PSW #140 and #132, #110 confirmed that resident #013 was not assisted with rest periods as directed in the plan of care, at times when the unit was not staffed as per the PSW staffing plan.

On an identified date Inspector #194 observed an identified meal, it was noted that thirteen residents were not present for the meal. Review of the staffing levels on the unit verified that PSW #109, #110 and #111 were working the day shift, two PSW positions were not staffed as per the PSW Staffing plan for the unit. During the observation period, six residents entered the dining room 19 minutes later. Seven residents in total did not attend the meal during the observation of the unit. Inspector #194 observed that two trays delivered to residents requiring assistance for feeding were provided the trays prior to staff being able to provide assistance.

During separate interviews, RN #123, #130, RPN #128, PSW #132, PSW #140, PSW #127, PSW #109, #110, #111 all indicated that when the units are not staffed as per PSW staffing plan, the resident care needs such as longer wait times for call bells being answered, delay in providing care to resident's, getting resident's to the meal and baths were being missed.

Resident #049, indicated that after calling for assistance, they waited several hours for staff to provide continence care. Resident #049 indicated staff had advised they were short staffed and would get to the resident when they could.

Resident #019 indicated being able to inform staff when toileting was required to remain continent. Resident #019 indicated that at times the resident has become incontinent while waiting for staff to provide assistance in toileting. Interview with PSW #140 indicated that resident #019 is not always continent, but that resident #019 is aware when incontinence has occurred and will ask to be changed. PSW #140 indicated that when working short staffed, the unit staff are unable to get to resident #019 right away, resulting in the resident becoming incontinent at times.

Review of the bathing schedules for resident #004, #030, #039 for an identified period, were completed by Inspector#194. Resident #004 was identified to have missed a number of baths, resident #030 was identified to have missed a number of baths, and resident #039 was identified to have missed a number of baths during the reviewed period.

The licensee has failed to ensure that the staffing plan provided for a staffing mix consistent with the residents' assessed care and safety needs. Personal care, including monitoring of food and fluid intake, toileting, bathing were not provided to residents consistently and resident safety related to supervision, the delayed answering of nurse call bells puts residents at potential risk for falls and injury.(194) [s. 31. (3)]

Additional Required Actions:

CO # - 002 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. 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 ensured that there written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The licensee's "Abuse and Neglect of a Resident - Actual or suspected" policy G-1, was reviewed, during the inspection into an abuse incident involving resident #005 and resident #011.

The licensee's "Abuse and Neglect of a Resident - Actual or Suspected" policy indicated that;

The nurse will:
- Immediately notify the DOC/Administrator

The DOC or designate will:
- Notify the MOHLTC Director immediately according to protocols established for

reporting of abuse and critical incidents.
- Obtain written statements from concerned parties.

Related to Log #007792-18:

CIR involving an incident of abuse involving resident #005 and resident #011 was reported to the Director one day after the incident took place.

RPN #155 reported an incident of abuse involving resident #005 and resident #011 to RN #143.

Review of the internal abuse investigation report and the CIR indicated that the MOHLTC was not notified of the incident until one day after it was reported to the RN #143, through after hours report #19400.

The licensee failed to ensure that the home's abuse policy was complied when the MOHLTC was not immediately notified of an abuse incident at the home involving resident #005 and resident #011.

Related to Log #007974-18:

CIR involving an incident of abuse involving resident #005 was not immediately reported to the Director and investigated.

CIR for resident to resident abuse involving resident #005 and an unidentified resident on an identified date.

During interview with DOC and review of the CIR it was indicated that the homes internal investigation into the reported allegation of resident to resident abuse to staff member #154, was not initiated until six days after it was reported. The Director was not notified of the resident to resident abuse until one day after the allegations were reported to staff member #154 by identified family member.

The licensee failed to comply with it's Abuse policy when the allegations of resident to resident abuse were not immediately investigated and reported to Director, when family member informed staff member or the allegations. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the licensee's Abuse policy is complied with, to be implemented voluntarily.

WN #4: 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 licensee has failed to ensure that any written complaints that was received concerning the care of a resident was immediately forwarded to the Director.

Related to Log#023302-18:

On an identified date a written complaint from family of resident #013 was submitted to the home. The written complaint indicated that the resident's call bell was activated and the family member waited 45 minutes to have staff assist. The complaint and interview with complainant indicated that the family member assisted the resident to bed when staff did not come and the resident's specified care was not provided.

DOC indicated during interview with Inspector #194 that the complaint and response to complaint were not forwarded to the Director.

Related to Log #023826-18:

On an identified date, the Director received a complaint from the Power of Attorney(POA) for resident #001. The complaint was related to personal nursing care for resident #001.

During a telephone interview, the POA indicated sending a letter, addressed to both the Administrator and the Director of Care(DOC) outlining concerns related to the care of resident #001 and also to report an incident which had occurred on an identified date, while the POA was visiting with the resident.

Review of the licensee's complaint file, contained a letter from resident #001's POA, related to concerns of personal care for resident #001 and staffing in the resident's home area.

Interview with the DOC confirmed the Director had not been informed of the complaint related to resident care and the operation of the home related to staffing.

The licensee has failed to immediately forward to the Director, the written complaints received from the Power of Attorney for resident #001 and family member of resident #013 concerning the care of the resident and the operation of the home .(166) [s. 22. (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 by ensuring that written complaints concerning the care of a resident are immediately forwarded to the Director, to be implemented voluntarily.

WN #5: 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 that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone.

Related to Log #007974-18:

During inspection of CIR for resident to resident abuse on an identified date, it was noted that a family member witnessed and unidentified resident displaying an identified responsive behaviour towards resident #005. A review of the home's internal investigation into the incident was completed by Inspector #194.

During interview with Inspector #194 the DOC indicated that Clinical Care Co-ordinator (CCC) #159, was responsible for completing the abuse investigation for the incident reported to MOHLTC on an identified date. CCC #159 was not available at the home for interview at the time of inspection and the licensee's investigation information was unavailable. DOC has confirmed that the home's investigation into the abuse was initiated by CCC #159, six days after the allegations were reported to the home.

The licensee failed to ensure that the allegation of abuse involving resident #005 was immediately investigated when reported to restorative care aide. The licensee's records indicate that the investigation into the allegations were not initiated until six days, after the home staff became aware of the abuse allegations. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that every alleged, suspected or witnessed incident of abuse is immediately investigated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse had occurred, immediately report the suspicion and the information upon which it was based to the Director.

Log # 007792-18:

A critical incident report was submitted to the Director related to abuse involving resident #005 and resident #011.

Review of the licensee's internal investigation of the abuse was competed and indicated that MOHLTC after hours, incident #19400, was notified of the incident one day after it was reported.

During interview with Inspector #194 the DOC has indicated that RN #143 was the designate in charge on the identified date.

The Critical Incident and licensee's internal investigation indicated that RPN #155 witnessed the abuse between resident #005 and #011. The internal investigation indicated that RPN #155 reported to RN #143 that resident #011 displayed an identified responsive behaviour towards resident #005.

During telephone interview with Inspector #194, RN #143 indicated that they were not able to remember many details related to the incident. The RN did not remember what was done, stating they notified the DOC and were informed that CIR would be completed the following day. RN #143 indicated they would have contacted DOC, all abuse is called to DOC and/or Administrator, at which point direction would be given as to how to proceed related to notification of the Ministry.

The internal investigation indicated that the MOHLTC was notified of the abuse the following day by another RN on duty.

Related to Log #07974-18:

During review of the CIR for resident to resident abuse witnessed by a family member. The CIR indicated that a family member had reported to the restorative aide an incident of abuse involving resident #005. The CIR describes a family member, having witnessed a resident displaying an identified responsive behaviour towards resident #005. The CIR indicated that the family member reported the incident a few days later to the restorative aide at the home.

During interview with Inspector #194 the restorative aide (RA) #154 indicated that the family member reported having witnessed the abuse involving resident #005, but was not aware of the resident's name or provide a description. RA #154 indicated during the interview that the incident was immediately reported, but due to the length of time since the incident, could not recall exactly to whom the information had been reported. RA #154 indicated that they felt it could have been RAI Coordinator #125.

During interview with inspector #194, the RAI Coordinator #125 indicated that due to the length of time since the incident they were unable to recall speaking to the family member directly related to incident. RAI Coordinator #125 indicated that if any contact with the family had been initiated, a progress note in the resident's clinical health record would have been initiated. Review of the clinical health records was completed and no progress note was found.

The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse had occurred involving resident #005, immediately reported to the Director. [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 by ensuring that any person who has reasonable grounds to suspect that abuse has occurred shall immediately report the suspicion and the information upon which it is based to the Director., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to bathe residents, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths.

Review of resident #039, #004 and #030 clinical health records related to provision of care specific to bathing was completed by Inspector #194.

Related to resident #039:

Review of the bathing scheduled posted indicated that resident #039 is scheduled for baths on two specific dates.

Review of the observation/flow monitoring form for resident #039 for an identified period related to bathing was completed by Inspector #194. The observation/flow monitoring forms indicated that for an identified period a number of baths were missed.

During separate interview with Inspector #194, during the inspection period, RN #123, #130, RPN #128, PSW #132, PSW #140, PSW #127, PSW #109, #110, #111 indicated that when the units are working without a full compliment of PSW staff, baths are missed.

Related to resident #030:

Interview with resident #030 was completed by inspector #194 related to bathing. Resident #030 indicated Inspector #194 that baths were completed. Resident #030 was asked if two baths a week were provided the resident, replied yes.

Review of the bathing scheduled posted indicated that resident #030 is scheduled for baths on two specific dates .

Review of the observation/flow monitoring form for an identified period for resident #030 was completed by inspector #194. The observation/flow monitoring form indicated that for an identified period a number of baths were missed.

Related to resident #004:

During interview with inspector #194, resident #004 indicated that they could not recall if they were provided two baths a week.

Review of the bathing scheduled posted indicated that resident #004 is scheduled for baths on two specific dates.

Review of the observation/flow monitoring form for an identified period for resident #004 was completed by inspector #194. The observation/flow monitoring for indicated that for an identified period a number of baths were missed.

The licensee failed to ensure that residents #039, #004 and resident #030 were bathed, at a minimum, twice a week by the method of their choice. [s. 33. (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 by ensuring that residents are bathed at a minimum, twice weekly by the method of their choice, to be implemented voluntarily.

WN #8: 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,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #019 who is unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence.

Review of the plan of care for resident #019 indicated that the resident is a two staff assist with transfer device. Resident #019's plan of care provided specific time for continence care to be provided, staff to praise attempts with being continent.

During interview with Inspector #194, resident #019 indicated that the call bell was not always answered promptly resulting in incontinence. Resident #019 indicated that frequently there was a long wait for staff to respond to the call bell, which at times resulted in incontinence.

During interview with Inspector #194, PSW #132 indicated to Inspector #194 that a specific unit was frequently working short. PSW #132 indicated that resident#019 is occassionaly continent and would ring or inform staff when assistance was required. PSW #132 indicated that when working short, resident #019 would request assistance for continence care but at times staff were late assisting the resident, resulting in incontinence.

The licensee has failed ensure that resident #019 whom is unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence. [s. 51. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Related to Log #019574-18, with reference to Log #026094-18:

During the review of the clinical documentation related to a CIR, it was identified that resident #050, experienced daily ongoing complaints of pain.

Review of resident #050 plan of care related to pain indicated that interventions were in place for the resident's pain management.

Review of Physician's orders related to pain medication over an identified period indicated :

Month one:
-routine and as needed pain medication was ordered.

Review of the electronic medication administration record (e-MAR), for the identified month indicated, pain medication was administered to resident #050, seventeen times for complaints of pain.

Month two:
-routine pain medication was discontinued and the as needed medication was increased.
Review of the e-MAR, for the identified month, indicated that pain medication was administered to resident #050, twenty -six times, for complaints of pain.

Month three:
-no changes to the pain medication orders.
Review of the e-MAR, for the identified month, indicated that pain medication was administered to resident #050, twenty -seven times for complaints of pain.

Month four and five:
- new order for routine pain medication ordered in month four and discontinued in month five.
- new orders for pain medication received in month four.
Review of the e-MAR's indicated that in month four, pain medication was administered to resident #050 , thirty-six times, for complaints of pain. In month five, a new order for pain medication was ordered and was administered every two hours, resident deceased early in month five.

PSW #158, indicate the resident would frequently call out in pain and would request pain medication . PSW #158 indicated the information related to the resident's complaints of pain would be given to the registered staff.

RN #130, indicated not being aware that pain assessments were to be completed when changes were made related to pain medication and /or when the pain medication was not effective.

Review of Medication Administration records for both the regular administered and the as needed pain medication indicated one pain assessment was completed when the order for new pain medication was initiated in the fourth month.

The licensee failed to ensure that when resident #050's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.(166)

Related to Log #009616-18:

A CIR was submitted to the Director, for an incident that caused injury to a resident for which the resident was taken to hospital and which results in a significant change in the resident's health status. The CIR indicated the following occurred:

Resident #003 had been in their mobility devices in a common area. The resident appeared to try to get up without assistance and fell. The resident was identified as a safety risk and was on 30 minute checks, a falls prevention device was also in place to alert staff if resident #003 was attempting to transfer. At the time of discovery, the falls prevention device was sounding. Resident #003 was assessed for injury by RN #117, there was no apparent physical injury, but the resident did complain of pain. The physician assessed the resident the following day and did not identify an injury, resident #003 continued to complain of pain in a specific area. Staff were to manage the symptom of pain and resident #003 remained on specific intervention until a one assessment was completed. Transfer status was changed for all transfers. On an identified date, resident #003 was expressing pain when the SDM was visiting, the resident was transferred to hospital and required medical interventions.

A review of the clinical records was completed by Inspector #623. There was no record of a pain assessment tool being completed for resident #003 for an identified period following the documented incident.

A review of the progress notes for an identified period, by Inspector #623 indicated the following:

-on day one, RPN #137 indicated that resident #003 was observed on the floor and appeared to have fallen. Upon assessment resident #003 indicated pain in a specific area. Routine pain medication was administered. RPN #137 indicated that resident #003 continued to complain of pain in a specific area. Resident #003 was also assessed by RN #117 and documentation also indicates that the resident expressed pain to the RN.

-on day two, RPN #137 documented that when staff were assisting resident #003, the resident was not weight bearing well and voicing complaints of pain in a specific area. The RPN also documented that the physician should be notified to assess the pain and to determine if further treatment was required. RPN #101 documented that pain medication was administered for complaints of pain from fall, with minimal effect.

-on day three, RPN #137 documented that the physician was in to assess the resident and felt that the pain was not a fracture. Physiotherapy was to assess the next morning. The Physiotherapist (PT) #161 documented an assessment of resident #003 post fall. The resident expressed pain in a specified area. Resident #003 was able to mobilize, minimally, with moderate discomfort. The PT recommended a change in transfer for resident #003 with no ambulation until reassessed. The physician was to be notified if symptoms worsened. RPN #128 documented that resident #003 received pain medication for pain with some effect.

-on day four, RPN #160 documented that resident #003 was experiencing pain in two specific areas. Resident's pain level was 7/10.

-on day five, RPN #128 documented that resident #003 received pain medication, the effectiveness was not documented. RPN #137 documented that resident #003 received pain medication for pain the effectiveness was not documented. RPN #137 also indicated that resident was observed to occasionally be rubbing a specific area, stating that they were not feeling well due to pain/discomfort.

-on day six, RPN #101 documented that resident #003 received pain medication for a specific pain. RPN #101 documented two hours later that pain medication was administered for pain/comfort prior to care. Resident was resistive to care therefore care was provided in intervals so resident could rest between tasks. RPN #137 documented that resident #003 received pain medication for pain in a specific area, the effectiveness was not documented.

-on day seven, RPN #122 documented that resident #003 complained of pain to a specific area and pain medication was given for comfort the effectiveness was not documented. RPN #137 documented that resident #003 was voicing complaints of pain to a specific area beginning of the shift. Pain medication was administered to resident #003 for pain, the effectiveness was not documented.

-on day eight, RPN #122 documented that resident #003 received pain medication for pain in a specific area, with good effect. RPN #137 documented that resident #003 received pain medication for pain in a specific area, the effectiveness was not documented.

-on day nine, RPN #122 documented that resident #003 complained of slight pain,

rubbing area. Routine pain medication administered. At a specified time, resident #003 began screaming out and complaining of pain. Unable to get resident #003 comfortable.

During an interview with Inspector #623, RPN #101 indicated that when a resident is experiencing pain, if it is an isolated incident then the nurse documents this in the progress notes. If the resident is being monitored for pain, then a paper pain assessment is to be completed and placed into the residents paper chart. There are two types of paper pain assessments, one that has facial expressions to describe pain that is used for a resident who cannot verbally express their pain, and one that is a series of questions written. RPN #101 indicated that they did not complete a pain assessment for resident #003 following the fall, and for a nine day period. RPN #101 indicated that resident #003 was experiencing pain daily during that time. RPN #101 indicated that resident had routine pain medication was administered twice daily, and the resident could have as needed pain medication in between.

During an interview with Inspector #623, RPN #128 indicated that they were unaware of the pain policy or if there were specific pain assessments that were to be completed for any resident with new or worsening pain. The RPN indicated that if they administered a PRN pain medication, it was documented in the progress notes and they did not complete any pain assessments. RPN #128 indicated that following resident #003's fall, they did work with resident #003 for three shifts. The RPN could not recall if they administered as needed pain medication, but did recall that the resident appeared to be in pain. RPN #128 indicated that they did not notify the physician that resident #003 continued to experience pain following the fall, until the transfer to hospital nine days later.

During an interview with Inspector #623, RN#103 indicated that the staff were asked to monitor resident #003 for pain. This should have been completed on a pain flow record or on a pain assessment, both are paper documents. RN #103 indicated that if resident #003 was identified as experiencing pain greater than 4/10 for 24-48 hours, the physician should have been notified. There is no indication that the physician was notified when resident #003 was experiencing ongoing pain after the fall as identified in the progress notes.

During an interview with Inspector #623, RPN #122 indicated that after resident #003 was discovered on the floor on an identified date, the resident was assessed at the time by the RN and there was no indication that there was an injury, but the resident was indicating pain and would rub the area. Staff were monitoring resident #003 for pain in

the days following the falls and administered routine pain medication twice daily and as needed pain medication for pain. RPN #122 indicated that if a resident experiences 2-3 days of ongoing pain and the as needed pain medication was not effective, the physician should have been notified for further assessment. RPN #122 indicated that for a nine day period, resident #003 expressed and showed signs of pain daily, staff were administering medications as prescribed, but no pain assessment were completed and there was no indication that the physician was contacted when the resident's pain continued.

The licensee failed to ensure that when resident #003's pain was not relieved by initial interventions following a fall, that the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose(623)

Related to resident #004:

During Stage one of RQI, resident #004 was identified with moderate pain daily.

The resident was admitted into the home and was assessed for pain on admission using the Initial Assessment Tool for pain which indicated the resident hardly ever having pain.

Review of the quarterly MDS for resident #004 completed on an identified date indicated that resident #004 had moderate pain daily to specific areas.

A review of resident #004's written plan of care related to pain indicated: Arthritis (complaints of pain and burning to specific area). Interventions included: staff apply topical medication with some relief; assess pain for a set number of days to establish any patterns (i.e. pain relating to activity, time of day, mental status) and make use of the resident's verbalizations if capable; consult physician if medication ordered is ineffective; ensure resident is positioned comfortably at all times and turned frequently observe for signs of pain, and report to Registered Staff when resident is experiencing pain.

Review of resident #004's health record indicated that resident was started on a Pain Flow Record for an identified period. Review of the physician orders indicated on an identified date, two different pain medication were ordered twice daily for pain. There was also an order for pain medication as needed (PRN) every four hours for breakthrough pain.

Review of resident #004's progress notes for an identified period, indicated that the resident experienced increased pain as follows:

The progress notes indicated that over an identified period resident expressed pain on a number of occasions and was provided with pain medication

During an interview by Inspector #723 with PSW #140 and #120, both PSW's indicated that resident #004 would verbalize if the resident was in pain. Both PSW's indicated that resident #004 had pain to a specific area and that they would inform registered staff when resident #004's expressed pain.

During an interview by Inspector #723, RPN #101 indicated that resident #004 would verbalize when in pain. RPN #101 indicated that resident #004's pain was managed effectively with scheduled pain medications. RPN #101 indicated that a pain assessment was completed for residents on admission and when the resident reports/or observed to have new or increased pain. RPN #101 indicated that residents experiencing new or increased pain were assessed using the Pain Flow Sheet initially, then the Pain Assessment Tool and Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC) on paper and referred to the physician. The RPN confirmed unable to locate any further pain assessment tools for the resident after admission.

During an interview by Inspector #723, RN #123 indicated that resident #004 would verbalize when in pain. RN #123 indicated that resident #004's pain was managed with pain medication. RN #123 indicated that during a specified month, the resident had increased pain and was ordered an as needed pain medication. RN #123 indicated no recall when the most recent pain assessment was completed for resident #004. RN #123 stated the pain assessments were done on admission and whenever there were changes in the resident's condition/or increased pain. RN #123 also indicated that the home utilized the Pain Scales monitoring, Pain Flow Sheet, PACSLAC to assess resident 's pain. RN #123 indicated that registered staff were responsible for completing the assessments and were documented on paper. RN #123 confirmed there were no documented pain assessments completed for resident #004, after the initial admission assessment, despite having an increase in pain and new pain medication.

During an interview by Inspector #723, the DOC indicated that pain reassessments were to be completed and documented by registered staff on the unit as per the policy. The DOC indicated the home utilized the Pain Assessment Tools, PACSLAC and Pain Flow Sheet when assessing residents. The DOC confirmed that the registered staff failed to reassess when resident #004 had increased pain.

The licensee failed to ensure that when resident #004's pain was not relieved by initial interventions, the resident was re-assessed using a clinically appropriate assessment instrument specifically designed for this purpose.(723) [s. 52. (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 by ensuring that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #026, #032 who required assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

On an identified date inspector #194 observed a meal service on specific area.

Inspector #194 toured the home area and noted that thirteen residents were not present in the dining room for the meal. During the observation period, six resident entered the dining room over a 19 minute period. Seven residents in total did not attend the meal during the observation of the unit.

At a specified time, PSW #110 delivered the trays to residents #026 and #032. Ten minutes later, Inspector #194 observed residents who had received meal trays in their rooms. Resident #032 was sleeping with the tray on an over the bed table, but did start to eat unassisted later. Resident #026 was sitting receiving a medication treatment, the meal tray was left on an over the bed table, in front of the resident. Seven minutes later, PSW #111 indicated that resident #032 was the only resident who required assistance with eating. Six minutes later, PSW #110 assisted resident #032 with the meal, thirteen minutes after the tray was provided.

Nineteen minutes after being provided the meal tray, resident #026 was observed sitting in their room with medication treatment still in place and meal tray untouched in front of them. Resident #026 indicated to Inspector #194 that they were able to eat unassisted. A few minutes later Inspector #194 observed PSW #111 removing the tray from resident #026's room. PSW #111 indicated to Inspector #194, that resident #026 did not want to eat but kept a few items from the tray, stating that the medication treatment was still in place. PSW #111 indicated to Inspector #194 that the registered staff were responsible for applying and removing the medication treatment. During interview with resident #026 immediately after the tray was removed, resident #026 expressed that they could not eat with the medication treatment in place, but stated to Inspector #194 that they probably would have eaten if the medication treatment was discontinued.

RN #112 indicated that RPN #101 had applied the medication treatment for resident #026. RN #112 indicated not being aware that the treatment for resident #026 had not been discontinued. RN #112 went to resident's room to discontinue treatment and returned to inspector #194 to report that the treatment was off.

Review of the plans of care for resident #026 and #032 were completed and indicated that both residents required assistance and supervision during meal service.

The licensee failed to ensure that resident #026 and #032 who required assistance with eating or drinking were served a meal before someone was available to provide the assistance required by the resident. [s. 73. (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 by ensuring that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A review of the recent medication incident quarterly review was completed and the last medication incident in that quarter was reviewed. Two additional medication incidents were also reviewed.

Review of Medication Incident #1, related to resident #024:

On an identified date, RPN #101 discovered that RN #123 failed to administer a specified medication to resident #024 as prescribed. RPN #101 discovered the medication incident during shift count when the actual count did not match with the controlled substance shift count and the medication was left in the blister pack.

A review of resident #024's Medication Administration Record (MAR) for the identified month indicated that the specified medication was signed off as given by RN #123.

During an interview with Inspector #723, RPN #101 indicated that they had discovered

the medication incident when the shift controlled substance sign in sheet did not match with the individual medication count. RPN #101 confirmed with RN #123 that resident #024's specified medication was still in the blister pack despite being signed off as given in the e-MAR and controlled substance sheet. RPN #101 was unable to locate the original individual and shift controlled substance count sheet for resident #024.

During an interview with Inspector #723, RN #123 indicated that resident #024 missed their specified medication despite being signed off in the e-MAR when the actual count was not the same as the paper sheet. RN #123 was unable to locate the original individual and shift controlled substance count sheet for resident #024.

Review of Medication Incident #2, related to resident #033:

On an identified date, resident #033 did not receive a number of medications as prescribed. RPN #137 discovered that RPN #101 failed to administer a number of medications, when RPN #137 found a medication cup containing the medications in resident #033's medication bin.

A review of resident #033's e-MAR for the identified month indicated that the medications were signed off as not given by RPN #101. There was no documentation on the e-MAR or the resident's progress notes at that time to indicate why the medications were not given. A progress note was completed six days later, indicating that the resident refused the medications, after the medication incident was reported.

During an interview with Inspector #723, RPN #101 indicated that resident #033 refused the medications at the time of administration and the medications were left inside resident #033's medication bin. RPN #101 indicated a progress note was completed that the resident refused the medications. The RPN confirmed that the note was completed six days later, after the medication incident was reported and confirmed that the incident was a medication error.

Review of Medication Incident #3, related to resident #034:

On an identified date, an unidentified RN reported that resident #034 did not receive their routine medication as prescribed.

A review of resident #034's e-MAR for the identified month indicated that on the identified

date the routine medication was signed as given by RN #103 and not RN #143.

During an interview by Inspector #723, RN #103 indicated they did not administer the routine medication to resident #034 on the identified date because they were not at work that day and indicated someone else must have signed their name in the e-MAR. RN #103 confirmed that resident #034 did not receive their medication as prescribed by RN #103, despite the e-MAR indicating it was given.

The licensee had failed to ensure that drugs were administered to resident #024, #033 and #034 in accordance with the directions for use, as specified by the prescriber. [s. 131. (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 by ensuring that drugs are administered to residents in accordance with the directors for use specified by the prescriber, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee had failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home: where a controlled substance is destroyed, including documentation as per section 136 (4).

A review of the recent medication incident quarterly review was completed and the last medication incident in that quarter was reviewed. Two additional medication incidents were also reviewed.

A review of Medication Incident #1, involving resident #024, indicated the resident was not administered a specified medication as prescribed, despite being signed on the e-MAR as given by RN #123. The medication incident was discovered by RPN #101 when the end of shift controlled substance count was noted to be incorrect.

During an interview with Inspector #723, RN #123 and RPN #101 indicated that they were unable to locate the individual and shift controlled substance count sheet for this resident.

During an interview with Inspector #723, the DOC indicated that registered staff are expected to retain resident's health records such as the controlled substance/narcotic count sheets, maintained in the resident's chart. The DOC confirmed they were unable to locate the individual and shift controlled substance count records related to this incident.

The license failed to ensure that a drug record was kept in the home for at least two years, where a substance is destroyed, including documentation as per section 136 (4) as the home was not able to locate the individual or shift controlled substance/narcotic count sheet for resident #024. [s. 133.]

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 by ensuring that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home: where a controlled substance is destroyed, including documentation as per section, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee had failed to ensure that every medication incident involving a resident is documented, together with the record of immediate actions taken to assess and maintain the resident's health.

A review of the recent medication incident quarterly review was completed and the last medication incident in that quarter was reviewed. Two additional medication incidents

were also reviewed.

Review of Medication Incident #1, related to resident #024 indicated RPN #101 discovered that RN #123 failed to administer a medication to resident #024.

A review of resident #024's progress notes for an identified period had no documented evidence that the resident was assessed or monitored related to the medication incident.

During an interview with Inspector #723, RN #123 and RPN #101 indicated that resident #024 was not assessed or monitored post medication incident.

Review of Medication Incident #2, related to resident #033 indicated that resident #033 did not receive a number of medications as prescribed.

A review of resident #033's progress notes for an identified period had no documented evidence of an assessment and monitoring of resident #033's after the medication incident.

During an interview with Inspector #723, RPN #101 and RPN #137 indicated that they did not complete or document assessments after the medication incident.

Review of Medication Incident #3, related to resident #034, indicated an unidentified RN reported that resident #034 did not receive their routine medication as prescribed.

During an interview with Inspector #723, RN #103 indicated that resident #034 did not receive their medication as prescribed, as RN #143 did not administer the routine medication to resident #034 on the identified date. The RN #143 stated that they were not working at the time of the incident.

A review of resident #034's progress notes for an identified period indicate no documentation that the home carried out assessments to monitor the resident's health when the resident missed their routine medication.

During an interview with Inspector #723, RN #103 indicated that the expectation is that when a medication incident occurs, that registered staff are to document an assessment and or monitoring of the residents involved, in the resident's progress notes.

The licensee failed to ensure that three residents involved in medication incidents, had a

documented record to indicate that immediate actions were taken to assess and maintain the residents' health after a medication incident. [s. 135. (1)]

2. The licensee had failed to ensure that all medication incidents are documented, reviewed and analyzed, corrective action is taken as necessary and a written record is kept of everything required under clauses a and b.

A review of the recent medication incident quarterly review was completed and the last medication incident in that quarter was reviewed. Two additional medication incidents were also reviewed.

Review of Medication Incident #1, related to resident #024, in which RPN #101 discovered that RN #123 failed to administer a specified medication to resident #024.

During an interview with Inspector #723, RN #123 indicated with regards to Medication Incident involving resident #024, the information written in the corrective plan of action on the Medication Related Incident Report form was written by the RPN #101. The RN #123 indicated that the DOC did not discuss the medication incident with the RN but received a letter from the DOC that the RN was required to complete further education.

During an interview with Inspector #723, the DOC indicated that they did not recall giving RN #123 a letter. The DOC did not have any documented evidence to support the a written letter was given to the RN regarding this medication incident.

Review of Medication Incident #2, related to resident #033, in which resident #033 did not receive a number of medications as prescribed.

During an interview with Inspector #723, RPN #137 indicated with regards to Medication Incident involving resident #033, that the RPN was unable to recall if the DOC discussed the medication incident with the RPN.

Review of Medication Incident #3, related to resident #034, in which resident #034 did not receive their routine medication from RN #103 despite being signed as given by the RN.

During an interview with Inspector #723, RN #103 indicated with regards to Medication Incident involving resident #034, that the RN did not administer the routine medication to resident #034 as indicated in the e-MAR.

During an interview with Inspector #723, the DOC indicated that they were unable to determine who the unidentified RN was on the medication incident and the DOC was not aware that the incorrect RN was identified as being involved in the medication incident.

During an interview with Inspector #723, the DOC indicated they did not have any documented evidence that a review and analysis for any of the medication incidents in the home had been completed. The DOC also confirmed that the information provided in the 'corrective plan of action' on the Medication Related Incident Reports were completed by the registered staff who were discovering the medication incidents. The DOC also stated investigation of medication incidents do not necessarily lead the DOC to talk to the staffs involved in medication incidents, however they were either required to take a medication exam or review of CNO standards.

The licensee had failed to ensure that medication incidents for residents' #024, #033 and #034 were reviewed and analyzed, and a documented record was kept of any corrective action taken as necessary to prevent a recurrence. [s. 135. (2)]

3. The licensee had failed to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home, since the time of the last review, in order to reduce and prevent medication incidents.

During an interview with Inspector #723, the DOC indicated a review of the home's quarterly medication incidences were carried out during the Professional Advisory Committee (PAC) meetings. The DOC stated that the home carried out PAC meetings quarterly. The DOC indicated they started in the DOC position in the first quarter and only attended their first PAC meeting on third quarter. The DOC confirmed that at this PAC meeting, the medication incidences were not reviewed as they were not aware that medication incidents were to be reviewed. The DOC also stated the Administrator kept the minutes for the PAC meetings and would be able to provide the PAC meeting minutes. The DOC confirmed there was no quarterly interdisciplinary meeting to evaluate the effectiveness of the medication management system.

During an interview with Inspector #723, the Administrator indicated that the review of the home's medication incidents were completed during the PAC meetings. The Administrator indicated that the PAC meetings were attended by the interdisciplinary team of the home which included home's Medical Director, Administrator, Activity Director, ESM, Nurse Practitioner, DOC, Clinical Care Coordinator, Pharmacists and RAI

Coordinator. The Administrator also indicated that the home's pharmacy service provider, completed the review and analysis of the home's medication incidents and was documented. The Administrator indicated there was a PAC meeting for the first quarter, but was unable to locate the meeting minutes. The Administrator stated there was no PAC meeting for the second quarter.

The Administrator was only able to provide PAC meeting minutes for the third quarter. The agenda items for this meeting did not include reviewing the medication incidents. The Administrator then provided the pharmacy's analysis form. A review carried out by the pharmacy indicated that the last medication incident review was completed over an identified period and the review indicated the home had an identified number of medication incidents during this period, a number of which directly involved the resident.

The licensee failed to ensure a quarterly review was completed of all medication incidents that occurred in the home since the time of the last review, in order to reduce and prevent medication incidents as: the home was only able to provide one PAC meeting minutes in 2018 which did not include review of the medication incidents in the home. The medication incidents in the home were only reviewed by the pharmacy and were reviewed for an identified period. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, in addition all medication incidents documented, reviewed and analyzed, corrective action taken as necessary and a written record is kept, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (4) No licensee shall,
(a) hold more than $5,000 in a trust account for any resident at any time; O. Reg. 79/10, s. 241 (4).
(b) commingle resident funds held in trust with any other funds held by the licensee; or O. Reg. 79/10, s. 241 (4).
(c) charge a resident, or a person acting on behalf of a resident, a transaction fee for withdrawals, deposits, or anything else related to money held in trust. O. Reg. 79/10, s. 241 (4).

s. 241. (7) The licensee shall,
(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that they have not held more than $5,000 in a trust account for any resident at any time.

Review of the Trent Valley Lodge, Trust Accounts Summary, indicated more than $5,000 was being held in resident #018's trust account.

The licensee has failed to ensure that they have not held more than $5,000 in trust for resident #018. [s. 241. (4) (a)]

2. The licensee has failed to ensure that a quarterly itemized statements is provided to the resident, or to a person acting on behalf of a resident respecting money held by the licensee in trust for the resident, that include: deposits, withdrawals and the balance of the resident's funds as of the date of the statement.

Interview with resident #001's Substitute Decision Maker(SDM) indicated, resident #001 did have a trust account held by the LTCH. The SDM indicated, not receiving quarterly statements related the balance in resident#001's trust account.

Interview with the AA indicated it was their responsibility for resident billing and for the management of the residents' trust account.

During the interview the AA identified residents #001 #014, #015, #016, #017, as residents who do not use the monies in their trust account and therefore a quarterly statement were not provided to the residents /or to the persons acting on the residents' behalf.

The licensee has failed to ensure that quarterly itemized statements related to the residents' trust account, which is to include: deposits, withdrawals and the balance of the resident's funds was provided to residents #001, #014, #015, #016, #017, or to the persons acting on behalf of the residents respecting money held by the licensee in trust for the resident. [s. 241. (7) (f)]

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 by ensuring that the licensee does not hold more than 5,000 in a trust account for any resident at any time and that a quarterly itemized statement is provided to all residents, or to a person acting on behalf of a resident respecting money held by the licensee in trust for the resident that includes: deposits, withdrawals and the balance of the resident's funds as of the date of the statement, 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. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident #005's SDM was notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Related to Log # 007974-18:

Review of CIR for resident to resident abuse submitted to the Director was completed by Inspector #194 and indicated that the SDM was not immediately notified of the abuse.

During interview with Inspector #194, staff member #154 indicated being in a resident room when family member reported the allegations which had occurred during a specified period of time, involving resident #005.

Review of resident #005's progress notes and review of the CIR indicated that SDM for resident #005 was not informed of the allegations of abuse involving resident #005 until six days after it had been reported to the home.

The licensee failed to ensure that resident #005's SDM was notified within 12 hours upon becoming aware of the reported allegations of abuse involving resident #005. [s. 97. (1) (b)]

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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response has been made to the person who made the complaint, indicating:
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief

Related to Log #023826-18:

On an identified date, the Director received a complaint letter from the Substitute Decision Maker(SDM) for resident #001. The complaint was related to concerns of personal nursing care for resident #001.

During a telephone interview, resident #001's SDM indicated sending a letter, addressed to both the Administrator and the Director of Care(DOC) outlining concerns related to the care of resident #001, staffing in the resident's home area and also to report an incident which had occurred on a specified date, while the SDM was visiting with the resident.

Review of the licensee's complaint file, did contain a letter from resident #001's SDM, related to concerns of personal care for resident #001 and staffing within the resident's home area.

Telephone interview with the SDM, indicated the Administrator and DOC had received the letter of concern from the SDM and the DOC indicated having had verbal communication with resident #001's SDM. However the SDM indicated there had been no written response forwarded to SDM from the Administrator or the DOC indicating what had been done to resolve the complaint.

Interview with the DOC confirmed resident #001's SDM had not receive a written response related to the complaint.

The licensee has failed to ensure that a response was made to resident #001's, Substitute Decision Maker related to the written complaint made to the licensee, concerning the care of resident #001 and the operation of the home. [s. 101. (1) 3.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to make a report to the Director under subsection 23 (2) of the Act, in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report.

Related to Log #023322-18:

On an identified day, an after hours call was received reporting an alleged incident of resident to resident abuse.

The DOC confirmed a written report related to this incident was not submitted to the Director.

The licensee failed to submit a written report with respect to the alleged incident of abuse of a resident involving resident #004 and #050. [s. 104. (1) 1.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later that one business day after the occurrence of the incident of:
4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Note: "significant change" means a major change in the resident's health condition that,

will not resolve itself without further intervention,
impacts on more than one aspect of the resident's health condition, and
requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

Related to Log #009616-18:

A CIR was submitted to the Director, for an incident that caused injury to a resident for which the resident is taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated the following occurred:

The CIR indicated that resident #003 had been in their mobility device in a specified area. The resident appeared to try to get up without assistance and fell. The resident was identified as a safety risk and was on 30 minute checks, a fall prevention device was also in place to alert staff if resident #003 was attempting to transfer. At the time of discovery, the fall prevention device was activated. Resident #003 was assessed for injury by RN #117, there was no apparent physical injury but noted that the resident did complain of pain. The physician assessed the resident the following day and did not identify an injury, resident #003 continued to complain of pain in a specific area. Staff were to manage the symptom of pain and resident #003 remained on a specified intervention until one assessment was completed. Transfer status was changed for all transfers. On an identified date resident #003 was expressing pain when the SDM was visiting the resident was transferred to hospital for assessment required medical interventions.

During an interview with Inspector #623, RN#103 indicated that at the time the incident involving resident #003, they were in the position of ADOC, and were responsible for submitting Critical Incidents to the Director. RN #103 indicated that on the identified date, resident #003 experienced a fall. The initial assessment did not indicate any obvious injuries. The resident did however indicate that they were having pain, but the resident was difficult to assess due to cognitive impairment. The resident continued to experience ongoing pain daily and 9 days after the initial fall, resident #003 was transferred to the hospital for further assessment. RN #103 confirmed that the CIR was not submitted to the Director until, two days after becoming aware that resident #003 had a significant change in status. RN #103 indicated that they were aware of the reporting requirements and were uncertain why the report was submitted late.

The licensee failed to ensure that the Director was informed no later that one business day after the occurrence of the incident that caused an injury to resident #003, that results in a significant change in the resident's health condition and for which the resident was taken to a hospital. [s. 107. (3)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 11th day of February, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194), ADELFA ROBLES (723), CAROLINE TOMPKINS (166), SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2018_603194_0019
Log No. / No de registre :	025783-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 16, 2019
Licensee / Titulaire de permis :	Trent Valley Lodge Limited 195 Bay Street, TRENTON, ON, K8V-1H9
LTC Home / Foyer de SLD :	Trent Valley Lodge 195 Bay Street, TRENTON, ON, K8V-1H9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kelly Slawter

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To Trent Valley Lodge Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Specifically the licensee must:
a) ensure assistance with food and fluid is provided and documented for residents as specified in the plan of care.
b) ensure residents are provided baths and the baths are documented as specified in the plan of care.
c) ensure the toileting needs for all residents is provided as directed in the plan of care and that the toileting care is documented.
d) ensure that rest/sleep routines are provided as specified in the plan of care.
e) ensure that residents with responsive behaviours, specifically resident #009 and #005, are provided the interventions to manage the behaviours, as specified in the plan of care. The intervention when implemented are documented.
f) Develop and implement a process to ensure that residents are receiving the care as set out in their plans of care.
g) Develop and implement a process to ensure that PSW and Registered staff are involved and updated with changes being made to the resident's plan of care.

Grounds / Motifs :

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

During this Resident Quality Inspection (RQI), Four CIR and five complaints by separate individuals and resident family members related to concerns of resident care and risk to resident safety were submitted to the Director and inspected.

Related to Log #023826-18:

The Power of Attorney (POA) for resident #001, submitted a complaint indicating that on an identified date, when visiting they found resident #001, unattended, without a meal during a specified meal service.

Review of the licensee's investigation, interview with the POA and the Director of Care, indicated that when the resident's POA asked a Dietary Aide (DA), if resident #001 had received their meal, the response was no. The DA advised the POA, the staff were busy with other residents and would get to resident #001 when they were finished.

Review of resident #001 plan of care related to food and fluid intake, outlined specified interventions related to the requirement of assistance.

Review of the complaint letter and interview with resident #001's POA, indicated,that the POA witnessed co-residents pushing the call bell for assistance. When assistance did not come for an extended period of time, the co-residents remained in need of continence care, until the PSW staff were able to assist the residents.

PSW #158, indicated thirty-two residents reside in a specified home area. On an identified date, there were two PSWs, who were able to provide direct/total care to the residents working in this home area. The third PSW, assigned to this home area, was unable to provide direct resident care due to work restrictions. PSW #158, indicated, the two PSWs, were not able to provide toileting to those residents, who require two staff assist and/or the use of a mechanical device for transfers.The PSW indicated residents #041, 042, 043, 044, 045, and resident #046, were not provided continence care, as per the residents' plan of care.

Review of the plans of care related to continence for residents #041, 042, 043, 044, 045 and resident #046, indicated the six residents identified, required extensive assistance from two staff and the use of a mechanical device for continence care.

PSW #158, indicated resident #040, did not receive a scheduled bath on an identified date, as resident #040 requires extensive assistance and is designated

as requiring two staff for bathing. Review of the Point of Care (POC) documentation did not provide evidence that resident #040 was provided with an alternate bath schedule date.

PSW #158, indicated that if the two PSW staff were required for resident care, there would not have been a PSW staff available to assist residents while two person care was being provided to other residents.

Review of resident #040's plan of care related to bathing, outlined specified interventions related to the requirement of assistance.

Related to Log #025211-18, with reference to Log #002613-18 and Log #024605 -18:

On an identified date, the Power of Attorney (POA) for resident #047, submitted a complaint to the Director related to resident care and risk to resident safety.

Review of the complaint documentation and interview with the POA, indicated four PSWs were assigned to the specific home area. Two of those PSWs were not able to provide resident care due to work restrictions.

Of the thirty-two residents in this home area, the POA indicated approximately twenty of the residents required the assistance of two PSWs for transfers and toileting.

The POA indicated co-residents call bells were ringing for extended periods of time. The two PSWs, who were able to provide resident care were not able to respond within a reasonable time period as they were assisting co-residents.

Interview with PSW #120, indicated thirty-two residents resided in this home area, twenty-two residents of the thirty-two residents required the assistance of two PSW staff for care. PSW #120, did not provide resident names, however did indicate that residents were waiting for an extended period of time to have their call bells answered and toileting was delayed. The residents remained in need of toileting care, until PSW staff were able to attend to the residents. PSW #120 indicated that residents who require two staff assistance for bathing, where often not provided their preference for bathing.

During separate interviews, PSW #141 and #142, confirmed that residents, who require two PSWs for toileting, bathing and transferring were waiting for extended periods of time for assistance, remained in need of toileting care, were not provided their preferred bathing and were self- transferring, rather than waiting for staff to come an assist, when the home areas were not staffed as per the PSW staffing plan.

Related to Log #023302-18:

A complaint was received by the MOHLTC, indicating that the family member had concerns related to resident #013. The complaint and follow up telephone interview with Inspector #194 indicated that if the family was not present resident #013 would not be provided the assistance to have rest periods. The complaint also described an incident on an identified date when assistance for transferring was requested for resident #013 and not provided by the staff at the home.

Review of the plan of care for resident #013 was completed and indicated under sleep and rest that;
- Ensure resident #013 is offered the opportunity to lay down after lunch daily.

Inspector #194 reviewed the flow sheet for resident #013 related to rest and sleep, for a specified period. The flow sheet indicated that resident #013 was assisted for a rest period, as per the plan of care on eight occasions. The flow sheet for resident #013 for another specified period, indicated that rest periods were provided on two occasions.

During interview with Inspector #194, PSW #132 and PSW #110 indicated that a specified unit was frequently working short. PSW's explained that resident care needs such as resident #013 being assisted for rest periods was often not completed.

The DOC reviewed the complaint letter received from a family member of resident #013. The complaint letter indicated that resident #013 was not assisted to bed and provided specified care. The result of the home's investigation into the allegations confirmed that specified care for resident #013 was not provided on the identified date.

PSW #146 indicated that there were two PSW staff on the floor at the time, the call bells were ringing, we were trying to answer them as best we could. PSW #146 indicated, I remember seeing resident #013's family member and saw the call bell ringing, I did not speak to family or provide any care to resident #013.

PSW #147 indicated, not being aware that resident #013 had returned with family. PSW #147 indicated working with PSW #146, it was only the two of us on the floor at the time. PSW #147 indicated that they were providing care to another resident, and trying to keep up with call bell situation. PSW #147 indicated as they were bringing co-resident to their room, they noticed the family member of resident #013 standing in doorway. PSW #147 stated that they addressed the family member and stating they would return when they completed the co-resident's care. PSW #147 indicated that staff did not get back to provide any care for resident #013.

The licensee has failed to ensure that care set out in the plans of care for residents, #001, 041, 042, 043, 044, 045, 046, 047 and resident #040 were provided as specified, specifically related to the assistance and monitoring of food and fluid intake, bathing, toileting, sleep/rest and bedtime care.

Related to Log #004822-18 and Log #007792-18:

Two CIR's, were submitted to the Director related to resident to resident abuse during a specified period, involving resident #009.

A CIR indicated that resident #009 was witnessed by staff (unidentified) involved in an identified responsive behavior towards resident #012.

Another CIR indicated that resident #009 was witnessed by PSW #153 involved in an identified responsive behavior towards resident #005.

Resident #009 is described in the plan of care as being cognitively impaired. Review of the plans of care for resident #009 related to responsive behaviour, for a specified period was completed and identified a number of interventions.

PSW #140, #147, #156 and #157 indicated that resident #009 was on 15 min

checks and was to be separated from resident #005 and other specified residents. PSW #156 indicated that resident #009 could not be facing resident #005 in the common area, PSW #140 indicated resident #009 could be common area, if the resident was out of reach of other co-residents, as the resident would display an identified responsive behavior towards co-residents as they passed by. PSW #147 and #157 indicated that resident #009 was to be assisted by staff, to their room post meals.

Resident #009 was observed by Inspector #194 on an identified date in a common area with resident #005.

Resident #009 was observed by Inspector #194 on another identified date, in a common area, with co-resident #008.

The licensee failed to provide care as set out in the plan of care for resident #009. Resident #009 was observed by Inspector #194 on two separate occasions to be in common area with identified residents, without any barrier between the residents.(194)

Related to Log #007792-18, Log #007974-18, and Log #016566-18:

Three CIR's were submitted by the home for resident to resident abuse during the a specified period involving resident #005.

CIR indicated that resident #011 was witnessed by RPN #155 involved in an identified responsive behavior towards resident #005.

CIR indicated that an unidentified resident witnessed by family member, involved in an identified responsive behavior towards resident #005.

CIR indicated that resident #009 was witnessed by PSW #153 involved in an identified responsive behavior towards resident #005.

Resident #005 is described in the plan of care as, requiring extensive assistance by staff for all ADL's, totally dependent with eating and mobility. Resident #005 was high risk for falls and was on 30 minute checks.

Review of the plans of care for resident #005 related to ensuring that the resident was not involved in identified responsive behaviours from co-residents indicated:

-Resident #005 was on 15 minute checks to ensure the resident is safe from inappropriate behaviour by co-residents. Resident #005 was not to be left in the vicinity of any specified co-residents, unsupervised by staff.

PSW #156 indicated that interventions for ensuring that resident #005 is kept safe from identified responsive behaviour included, placing resident #005 behind the nursing station. PSW #156 also indicated that when resident #005 was agitated and displaying an identified responsive behavior, the resident would be assisted back to their room and falls prevention device was put in place.

PSW #147 indicated that interventions for ensuring that resident #005 was not involved in identified responsive behaviour, included keeping resident #005 away from specified residents and position resident #005 at nursing station when able, to be observed by staff.

PSW #157 indicated that interventions for ensuring that resident #005 was not involved in identified responsive behaviour, included postitioning resident behind the nursing station. PSW #157 indicated that if specified residents were in the common areas, staff would try and position resident #005 at the nursing station or place the resident in their room with the call bell. All PSW staff interviewed by Inspector #194 indicated that resident #005 was on 15 min safety checks.

Resident #005 was observed by Inspector #194 on an identified date in a common area with resident #009.

The licensee failed to ensure that care set out in the plan of care related to responsive behaviours for resident #009 and #005 were provided as specified. (194) [s. 6. (7)]

The severity of this issue was determined to be a level 2 as potential for actual harm. The scope of the issue was a level 2 as a pattern. The home had a compliance history as 3 as having one or more non compliance in the last 36 months that included:

- A voluntary Plan of Correction (VPC) issued on June 12, 2017, 2017_6013194_0016 (166)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 04, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 31(3) of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure a staffing mix that is consistent with residents' assessed care and safety needs. The plan must include, but is not limited to the following:
a) Ensure that the PSW staff mix identified in the PSW staffing plan is consistently provided to ensure the residents assessed care and safety needs are met.
b) Provide evidence of PSW recruitment and hiring at the home.
c) Ensure that the PSW back up plan is effective in providing resident assessed care and safety needs.

Please submit the written plan, quoting log, #2018_603194_0019 and Chantal Lafreniere, LTC Homes Inspector, MOHLTC, by email to CentralEastSAO.MOH@ontario.ca by February 4, 2019

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

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

During this Resident Quality Inspection (RQI), five complaints submitted by separate individuals and residents' family members were inspected.
These five complaints and interviews with the registered nursing staff and PSW staff indicated concerns that the provision of resident care and resident safety were being compromised as a result of staff not being replaced for sick calls and/or staff who are at work with specified work restrictions related to providing resident care.

During an interview with Inspector #194 and #166 , the DOC confirmed that the PSW staffing plan to accommodate residents in the home to be:
- 32 residents resided on a specific home area
- 38 resident resided on another specified home area
- 32 residents resided on another specified home area
- 14 PSW on a specified shift, 4 PSW on a specified resident home area, 5 PSW on another specified resident home area, 4 PSW on another specified resident home area and one float (to be assigned daily by registered staff)
- 11 PSW on another specified shift, 3 PSW on a specified resident home area, 4 PSW on another specified resident home area, 3 PSW on another specified resident home area and a float (to be assigned daily by registered staff)
- 6 PSW on another specified shift, 1 PSW on a specified resident home area, 2 PSW on another specified resident home area, 2 PSW on another specified resident home area and a float.

The DOC also indicated that PSWs on modified work restrictions were accommodated, but not backed filled. The DOC explained that PSWs identified with work restrictions, came to work and the float would pick up the duties that could not be completed by the PSW with work restrictions. There were currently a number PSW staff with work restrictions working in the home, not being replaced.

Review of the staffing schedule with Nursing/staffing clerk was completed by inspector #194 for a two month period, the review showed the following:
- During one identified month, there was a total of 64 PSW full shifts not staffed

and 80.5 hours of PSW partial shifts not staffed.
- During another identified month, there were 32 PSW full shifts not staffed and 28.5 hours of PSW partial shift not staffed.

The DOC has indicated that a proposal to change the PSW staffing schedule was drafted and proposed to the union but no specific changes had been made.

Related to Log# 023826-18:

The Power of Attorney (POA) for resident #001, submitted a complaint indicating concern for the care and safety for resident #001.

Review of the licensee's investigation, interview with the Director of Care, and during an interview with resident #001's POA, was completed. The POA observed resident #001 on an identified date during a specified meal time unattended without a meal. The POA asked a Dietary Aide (DA) if resident #001 had received their meal, the response was no. The DA advised the POA, staff were busy with other residents and would get to resident #001 when they were finished.

The POA, indicated on that same date, witnessing a number of other co-residents pushing the call bell and calling for assistance and when assistance did not come for an extended period of time, those residents remained in need of continence care, until the PSW staff were able to assist.

PSW #158, a full-time PSW staff in resident #001's home area was interviewed by Inspector #166. PSW #158, who was on duty, indicated thirty-two residents reside in this home area and there were two PSWs, who were able to provide direct/total care to the residents, the third PSW, assigned to this home area on that date was unable to provide direct resident care due to unspecified work restriction.

PSW #158 indicated that the PSWs were not able to return to the dining room to ensure resident #001 was supervised/assisted and had received meal, as the two PSWs were providing care to residents who required two staff assist.

PSW #158, indicated residents #041, 042, 043, 044, 045, and resident #046

were not provided continence care as these residents required extensive assistance from two staff and the use of a mechanical aid for continence care.

PSW #158, indicated resident #040, did not receive a scheduled bath, as resident #040 requires extensive assistance and is designated as requiring two staff for bathing. Review of the Point of Care (POC) documentation did not provide evidence that resident #040 was provided with an alternate bath schedule date.

PSW #158, indicated because two PSW staff were required to provide care /bathing/toileting to residents #041, 042, 043, 044, 045, 046 and resident #40, there would not have been another available PSW staff to assist any other resident while two person care was being provided.

Related to Log #002613-18, with reference to Log #024605-18 and Log #025211 -18:

The Power of Attorney (POA) for resident #047, submitted a complaint to the Director related to resident care and risk to resident safety.

Review of the complaint and during an interview with Inspector #166, resident #047's POA indicated, that on an identified date, four PSWs were assigned to a specific home area. Two of those PSWs were not able to provide resident care due to unspecified work limitations. The POA indicated on the identified date, resident #047, waited approximately 20 minutes to be transferred from the bathroom, as there was only one PSW available to assist and resident #047 requires two person assist for transfer/toileting.

The POA also indicated, that on seven separate dates, residents' call bells were ringing for extended periods of time. The two PSWs, who were able to provide resident care were not able to respond within a reasonable time period as they were with other residents who required two person assist with care.

PSW #120, indicated thirty-two residents resided in a specific home area, twenty-two residents required the assistance of two PSW staff for care.

PSW #120, did not provide resident names, however did indicate that residents

were waiting for extended periods of time to have their call bells answered, toileting care was delayed, residents remained in need of continence care until PSW staff were able to attend to those residents. The residents who required two staff assist for bathing, were not provided their preference for bathing.

On an identified date, separate interviews with PSW #141 and #142, confirmed that residents, who required two PSWs for toileting, bathing, transferring were waiting for extended periods of time for assistance, remained in need of continence care, were not provided their preference for bathing and are self-transferring rather than waiting for staff to come and assist, creating a potential safety risk related to falls.

Log # 23302-18 related to resident #013:

During interview with family member of resident #013, Inspector #194 was informed that a formal letter of complaint was submitted to the home related to care and transfer needs for resident #013 not being provided on an identified date. Review of the internal investigation into the concern verified that the home unit was not staffed as per the PSW staffing plan on the identified date. The PSW staff were unable to respond to the resident #013's call bell and family request to assist resident with care. Family member indicated that after 45 minutes of waiting for staff, they assisted the resident with the transfer but resident #013 was not provided specified care.

During separate interview with Inspector #194, PSW #140 and #132, #110 confirmed that resident #013 was not assisted with rest periods as directed in the plan of care, at times when the unit was not staffed as per the PSW staffing plan.

On an identified date Inspector #194 observed an identified meal, it was noted that thirteen residents were not present for the meal. Review of the staffing levels on the unit verified that PSW #109, #110 and #111 were working the day shift, two PSW positions were not staffed as per the PSW Staffing plan for the unit. During the observation period, six residents entered the dining room 19 minutes later. Seven residents in total did not attend the meal during the observation of the unit. Inspector #194 observed that two trays delivered to residents requiring assistance for feeding were provided the trays prior to staff

being able to provide assistance.

During separate interviews, RN #123, #130, RPN #128, PSW #132, PSW #140, PSW #127, PSW #109, #110, #111 all indicated that when the units are not staffed as per PSW staffing plan, the resident care needs such as longer wait times for call bells being answered, delay in providing care to resident's, getting resident's to the meal and baths were being missed.

Resident #049, indicated that after calling for assistance, they waited several hours for staff to provide continence care. Resident #049 indicated staff had advised they were short staffed and would get to the resident when they could.

Resident #019 indicated being able to inform staff when toileting was required to remain continent. Resident #019 indicated that at times the resident has become incontinent while waiting for staff to provide assistance in toileting. Interview with PSW #140 indicated that resident #019 is not always continent, but that resident #019 is aware when incontinence has occurred and will ask to be changed. PSW #140 indicated that when working short staffed, the unit staff are unable to get to resident #019 right away, resulting in the resident becoming incontinent at times.

Review of the bathing schedules for resident #004, #030, #039 for an identified period, were completed by Inspector#194. Resident #004 was identified to have missed a number of baths, resident #030 was identified to have missed a number of baths, and resident #039 was identified to have missed a number of baths during the reviewed period.

The licensee has failed to ensure that the staffing plan provided for a staffing mix consistent with the residents' assessed care and safety needs. Personal care, including monitoring of food and fluid intake, toileting, bathing were not provided to residents consistently and resident safety related to supervision, the delayed answering of nurse call bells puts residents at potential risk for falls and injury. (194) [s. 31. (3)]

The severity of this issue was determined to be a level 2 as potential or actual harm. The scope of the issue was a level 3 as it was widespread through out the home. The home had a level 2 history with one or more related non compliance

issued in the past 36 months with this section of the LTCHA that included:
- A Compliance Order (CO) #001 issued June 12, 2017 with a compliance dated of Augustt 18, 2017 (2017_603194_0017). . (166)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 04, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 16th day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

Service Area Office /
Bureau régional de services : Central East Service Area Office