Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 16, 2019	2019_595110_0005	016363-19, 017096-19	Complaint

Licensee/Titulaire de permis

Southlake Residential Care Village
596 Davis Drive NEWMARKET ON L3Y 2P9

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

Southlake Residential Care Village
640 Grace Street NEWMARKET ON L3Y 2P6

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

DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 28, 29, 30. September 4, 6, 2019.

The purpose of this inspection was complaint logs #016363-19 and # 017096-19 related to staffing changes and resident care needs were being negatively affected.

During the course of this inspection record reviews and staff interviews were completed with respect to two applicants.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, RAI Coordinator, Registered nurses, Personal Support Workers, Families and Substitute Decision Makers (SDM).

During this inspection the inspector conducted observations of resident care and services and reviewed relevant health records for specified residents.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is bathed, at a minimum, twice a

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

This Inspection Protocol (IP) was initiated related to a complaint, log #016363-19, that stated staffing levels were reduced and resident care needs were being affected.

A record review of resident #008's written plan of care identified the resident's bathing preference, scheduled days, times and the required number of staff for transfers.

A record review of the 'Follow up Question' report in point of care (POC) for bathing over an identified four week period revealed the following:
Week 1 - bath day #1- no documentation; bath day #2- bathing documentation by PSW #110.
Week 2 - bath day #1-no documentation; bath day #2 -bathing documentation by PSW #110.
Week 3 - bath day #1 -no documentation; bath day #2- bathing documentation by PSW #110.
Week 4 - bath day #1 - bathing documentation by PSW #111, bath day #2 no documentation, additional bath day- documentation by PSW #110.
Week 5 - bath day #1 - bathing documentation by PSW #110.

An interview with PSW #110 revealed they were unable to provide resident #008 with their scheduled bathing preference and their documentation in the 'Follow Up Question' report was only to acknowledge that a bed bath had been provided. A review of the POC Follow up Question report with PSW #110 revealed that there were four occasions when bed baths were provided and on another occasion where they were unable to complete the resident's bathing preference or bed bath but that they had cleaned the resident's arm pits and peri area. The PSW shared awareness that the resident's SDM would like resident #008 to be bathed, by their bathing preference twice a week but they had insufficient time.

An interview with RN #019 stated that since the staffing changes resident care has been affected including resident's baths and showers. The RN stated that it was now impossible to get everyone bathed twice a week. [s. 33. (1)]

2. This IP was initiated related to a family concern brought forward by resident #009's SDM to the Inspector during the inspection period.

An interview with resident #009's SDM revealed a concern that their relative, resident #009, had not been receiving their bathing preference for two months. The SDM stated that they would ask resident #009 and they would say no they had not been bathed and that they could also tell as the resident's hair appeared unclean. The SMD shared that when they visited on an identified date, after the resident's scheduled bathing time they noticed resident #009 smelling of urine and their hair unwashed. The SDM stated they had spoken with the charge nurse who confirmed the resident had not been bathed on the scheduled day and would ensure the resident was bathed the following day.

A record review of the written plan of care identified the resident's preferred date and time of bathing.

An interview with RPN #102 revealed that resident #009's SDM had been involved and communicated that they had noticed a decrease in care to resident #009..

An interview with resident #009 shared that they do miss their bathing and do not like the feeling when they are not clean.

A record review of the POC Follow Up Question Report failed to identify any bathing record for resident #009 over the two identified months the complainant referred to. A review of the resident's health record including progress notes, failed to include documentation of bathes being provided or missed during this two month period.

An interview with RAI coordinator #112 confirmed that resident #009 had not received the minimum if two baths per week over the two identified month period. [s. 33. (1)]

3. This IP was initiated related to a complaint, log #016363-19 that staffing levels have been reduced and resident care needs affected. As an area of non compliance was identified, the sample size was expanded to include resident #012.

An interview with resident #012's SDM shared that they were concerned that resident #012 was not receiving two bath per week and kept asking the staff to bath the resident. The SDM stated resident #012's hair often looked greasy, was itchy to resident #012 and that their fingernails were often dirty. The SDM stated they left a note in an identified month in the resident's room asking staff to bath and wash the resident's hair twice a week.

A record review of the resident's written plan of care identified that resident's bathing preference days and times and that the resident's nail care was to be provided (clean and trim) on first bath day of the week.

A review of the Follow Up Question Report related to bathing identified four entries over a two month or 8 week period related to bathing. The report did not specify the type of bathing that occurred, tub bath, shower or bed bath and there was no documentation related to the 13 missed baths over the identified eight week period.

An interview with PSW #101 revealed they remembered only bathing the resident one of the two days in two of the four bathing entries and the other day they provided the resident with a bed bath. The PSW shared the documentation in POC does not specify what type of bathing had occurred.

The bathing documentation of August 26, 2019 was documented by PSW #107.

An interview with PSW #107 revealed that they had bathed resident #012 on one of the four identified dates and that there was a note in the resident's night table from the resident's SDM that the resident had not been bathed and could the staff please bath the resident twice a week.

An interview with RAI coordinator #112 confirmed that resident #012 had not received the minimum if two baths per week in the two identified months.

An interview with the DOC shared that a bed bath was not a substitute for the resident's preferred bath or shower. The DOC further shared that when a resident's shower or bath was missed the resident should still be offered their bathing choice the next shift or next day to ensure a minimum of two baths per week. The DOC stated that if there was no documentation of bathing it was assumed it had not been completed. The DOC confirmed that not all residents had received bathing twice a week. [s. 33. (1)]

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. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

This IP was initiated related to complaint, Log #016363-19, whereby the complainant stated that resident #007's care needs, like teeth brushing were not met as a result of changes in staffing levels.

A record review of resident #007's written plan of care identified the resident's oral hygiene care needs; total dependence on staff and directed staff to take time in performing oral care.

During the inspection period at 0847hrs an observation was conducted of resident #007's bathroom to identify if the resident's toothbrush had been used for morning care.The resident was not in their room and the resident's regular toothbrush and toothpaste were identified, labelled with their name. The toothbrush was dry. At 1010hrs the Inspector returned to the resident's room with RPN #102 and confirmed the toothbrush was dry. An observation of resident #007's teeth was completed with the RPN who identified a significant plaque build up on the base of the resident's lower teeth.

PSW #113 was identified as the resident's PSW on same identified day. An interview with PSW #113 confirmed that they provided morning care to resident #007 and that the resident's care was to include teeth brushing. The PSW stated they were unable to brush

the resident's teeth as they did not have sufficient time.

An interview with RPN #102 identified that the expectation of staff was to brush the resident's teeth during morning care and that staff had not reported they had not had time. The RPN confirmed the resident had not received oral care in the morning. [s. 34. (1) (a)]

2. This IP was initiated as a result of non compliance being identified and therefore the sample size was expanded to include resident #006.

A record review of resident #006's written plan of care identified the resident's oral hygiene care needs; total dependence on staff and directed staff to to brush teeth and oral tissues and gums carefully.

During the inspection period at 0847hrs an observation was conducted of resident #006's bathroom to identify if the resident's toothbrush had been used for morning care. The resident was not in their room and the resident's identified toothbrush was observed as dry. At 1010hrs the Inspector returned to the resident's room with RPN #102 and confirmed the toothbrush was dry.

An observation of resident #006's teeth, completed with RPN #102, identified a build up of plaque on the resident's bottom teeth.

PSW #100 was identified as the resident's PSW on the same day. An interview with PSW #100 confirmed they provided morning care to resident #006 and the resident's care was to include teeth brushing. The PSW stated they did not brush the resident's teeth as part of morning care.

An interview with RPN #102 identified that the expectation of staff was to brush the resident's teeth during morning care and that staff had not reported that they had not had time.The RPN confirmed the resident had not received oral care in the morning. [s. 34. (1) (a)]

3. As a result of non compliance identified in this area the sample size was expanded to include resident #013.

During the inspection at 0900hrs an observation was conducted of resident #013's room to identify if the resident's toothbrush had been used for morning care. The resident was

identified asleep in bed. At 1148hrs the Inspector returned to the resident's room with RPN #102 where the resident was not present. The RPN confirmed the resident was in the dining room and that the resident's toothbrush was dry.

PSW #101 was identified as the resident's PSW on the same day. An interview with PSW #101 confirmed they provided morning care to resident #013 and that the resident's care was to included setting the resident up at the sink so the resident could brush their teeth. The PSW stated they did not set the resident up as their was another resident requiring a bath with two staff and they did not have time.

During an interview with RN #110 they stated the home area went from staffing 4 PSW on days to 3 and teeth brushing was one care area to residents that has been affected.

A separate interview with conducted with resident #004, cognitive and totally dependent on staff for care. The resident shared with Inspector that staff do not always brush their teeth in the morning.

An interview with PSW #113 revealed the staffing levels changed from 4 PSWs on days to 3 and lately on average they have two PSW staffed on evenings. The PSW stated that teeth brushing is one care area that has been affected.

An interview with SDM #018 of complaint log #017096-19 shared that care has "dropped like a stone in the last two months" and their resident's oral hygiene has been a problem and staff are not brushing the resident's teeth.

An interview with PSW #113 shared that teeth brushing is one care area that has been affected over the past few months. The PSW stated that they use to brush resident #003 teeth and now they have to swab their teeth and they are down to brushing the resident's teeth once per week.

The licensee failed to ensure that the resident receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures. [s. 34. (1) (a)]

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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

This IP was initiated related to resident #001's SDM who had expressed a concern to the Inspector during the inspection. The SDM shared their had been a lot of staffing cuts l in the home and the care to resident #001 had been affected.

During the interview, the SDM stated that on an identified day resident #001 did not get up for breakfast and the resident's breakfast tray was still in the resident's room late afternoon when they arrived to visit. The SDM stated that resident #001 was upset they did not get up for breakfast as they looked forward to going to the dining room. The SDM shared that they were informed by the RPN that they were short staffed during the day shift with only two PSWs.

An interview with PSW #114 confirmed they worked on the identified weekend revealed in the SDM's concern and worked short one PSW. The staff shared that resident #001 did not get up two days in a row for breakfast as they did not have time to get the resident up. The PSW stated that the resident normally goes to the dining room and on an identified date the resident shared with the PSW that they really wanted to get up and go to the dining room.

An interview with PSW #111 confirmed they worked the identified weekend they did work short. The staff could not recall resident #001 by name but stated their were residents who staff were unable to get up for breakfast in the dining room.

An interview with RPN #115 confirmed they worked the same identified weekend and that there were residents staff were unable to get up into the dining room for breakfast and that tray service was provided.

The licensee failed to ensure that care set out in resident #001's plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

2. This IP was initiated related to complaint, log #016363-19, whereby the complainant stated that resident #007's care needs, like getting up into the dining room for breakfast were not being met, as a result of changes in staffing levels.

In separate staff interviews, PSW #116 and PSW #104 stated that they were unable to get resident #007 up for breakfast in an identified morning during the inspection . PSW #116 stated the resident normally eats in the dining room, was last on their list to get ready and they ran out of time.

An interview with RPN #102 confirmed that there are times when staff are unable to get residents up who normally go to the dining room for breakfast.

3. This IP was initiated related to complaint log, #016363-19, revealing concerns of insufficient staffing and resident care needs not being met. As a result of non-compliance being identified the sample size was expanded to resident #004.

A record review was completed of resident #004's written plan of care which identified resident #004 requiring total assistance with eating and transfers. The written plan of care stated the resident's preference for when and where to have meals and be placed back to bed.

An interview with resident #004, observed sitting in their chair one hour after the time identified in the resident's plan of care directs staff to place the resident in bed. The resident shared that over the past few months staff have been unable to accommodate their preference of meal location and bed rest schedule. The resident share their personal desire of why they liked to go to the dining room.

An interview with PSW #100 confirmed that staff were sometimes unable to get resident #004 up for an identified meal as they could not commit to placing them back to bed in

the afternoon so the resident often agreed to stay in bed. A further interview with RPN #102 shared that resident #004 does not usually get up for an identified meal as sometimes the PSWs do not have time. The RPN shared that the resident's plan of care was not followed as their preference for getting up and going back to bed was not followed. [s. 6. (7)]

An interview with the DOC shared that the resident's plan of care would not have been followed if the staff did not provide the opportunity for the residents to go to the dining room for meals as specified in their plan. [s. 6. (7)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure the home's staff plan include a back-up plan for nursing

and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage).

This IP was initiated related to complaint log #016363-19 and 017096-19 whereby management was not replacing staff and fewer PSWs were caring for the the same number of residents and care was impacted. One complainant shared that when the scheduled staff could not come into work, staff are not being replaced; there was no plan and resident care needs are being affected. The complainant shared the impact to residents was mouthcare, teeth brushing, personal hygiene like not getting their faces washed. Bathing bed baths and with no scheduled baths or showers and not following their toileting all because staff were running out of time.

An interview with staffing clerk #103 stated the week of July 15, 2019 they were given notice to cut back on staffing shifts. The direction was anytime on days not to replace the 4th PSW on the unit, except for 3E and 5W and not to replace the second RN should they schedule a day off. The staffing clerk shared that it was their impression that direction was not provided to staff on the units when this change was initiated and there was no plan in place.

During the inspection period, family members #015, #016, #017, #018, #019, #020 and #021 sought out the Inspector and shared their concerns and negative experiences related to changes in care to their resident. Resident's #002, #013, #014 also independently requested to speak with the Inspector to shared care and staffing concerns.

An interview with RN #109 stated the staffing changed from 4 PSWs on days to 3 and it was "hear say" since the beginning of July as there was no official plan. The RN identified that resident care was affected; resident's teeth were not being brushed, not all residents were taken to the dining room for meals and residents maybe were showered once a week.

An interview with RPN #102 stated at the beginning of the summer they started to see the staffing change from 4 PSWs to 3 on days. The RPN shared that male residents were not being shaved daily; staff were unable to get all residents up for meals and residents were not always getting their regular bath or showers. The RPN stated there was no communication that the unit staffing was going down to 3 PSWs and sometimes they found out the day of and it was a case of taking eight more residents and splitting them amongst 3 staff.

The results of the inspection identified care not being provided to residents as outlined in this report.

An interview with the DOC stated staffing changes were made the end of June, early July and that they did not communicate directly with staff at the time and there were was not a plan put in place to ensure resident care and services were not affected. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work? (including 24/7 RN coverage, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

This IP was initiated related to complaint log #016363-19 stating insufficient staffing and resident care needs not being met.

During staff interviews the Inspector asked if beverage or snack service was ever not offered to residents. PSW interviews confirmed that a morning beverage pass was not offered on an identified date related to running out of time.

An interview with PSW #113 confirmed that they worked the day shift of the identified

date and were unable to offer a morning beverage to residents as they were completing showers and ran out of time to complete the beverage pass. The PSW shared that resident #002 was the first who noticed and asked where their labelled food item was as it was offered during the morning beverage pass.

A review of resident #002's 'Follow Up Question Report -Fluids Consumed- At meals and nourishments' located in POC was completed. There was no documentation for the day shift of the identified date in question.
A review of resident #002's written plan of care identified the dietary intervention to be provided at AM snack.

An interview with PSW #104 confirmed they worked with PSW #113 on the identified date. The PSW shared that they thought the beverage pass had been completed but that they found out from resident #002 that it had not been served.

An interview with resident #002 revealed they could not recall specifically if they were offered a between-meal beverage and their dietary intervention in the morning of the identified date but stated "some days they miss". The resident shared their perspective on the changes to staffing levels and that "the girls have no time to stop in".

An interview with the DOC identified that residents are to be offered a minimum of a between-meal beverage in the morning. [s. 71. (3) (b)]

2. This IP was initiated related to a complaint, log #017096-19, whereby the complainant expressed the quality of care has dropped "like a stone" in the past two months, that resident #010 can not drink independently and staff are requesting families to provide assistance and that staff are not brushing the resident's teeth.

On an identified date resident #010's room was observed by Inspector from across the hallway. At 1025hrs a beverage cart was identified in the hallway and drinks were being served by PSW #105. Between 1025hrs and 1054hrs no beverage was offered to resident #010.

A record review identified the resident required total assistance with food and fluids. A recent progress note entitled 'Nutrition Note' documented by the registered dietitian identified resident #010 at high nutritional risk as the resident had a baseline poor fluid intake.

An interview with PSW #105 revealed they had not offered resident #010 a morning beverage as there was a lack of staff. The PSW shared two staff use to deliver beverages and assist residents and now there was only one PSW. The PSW shared that they would document the beverage pass as "Not applicable".

An interview with PSW #106, who provided morning care to resident #010, revealed that they did not serve a between meal beverage to resident #010.

The licensee failed to ensure residents are offered a minimum of a between-meal beverage in the morning. [s. 71. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, to be implemented voluntarily.

Issued on this 24th day of October, 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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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) :	DIANE BROWN (110)
Inspection No. / No de l'inspection :	2019_595110_0005
Log No. / No de registre :	016363-19, 017096-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 16, 2019
Licensee / Titulaire de permis :	Southlake Residential Care Village 596 Davis Drive, NEWMARKET, ON, L3Y-2P9
LTC Home / Foyer de SLD :	Southlake Residential Care Village 640 Grace Street, NEWMARKET, ON, L3Y-2P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anne Deelstra-McNamara

To Southlake Residential Care Village, 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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 :

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

Order / Ordre :

The licensee must be compliant with the O. Reg 79/10, s 33. (1).

The licensee is ordered to:
1. Ensure that resident's #008, #009 and #012 are bathed, at a minimum, twice a week by the method of his or her choice.
2. Ensure that all resident's are bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Grounds / Motifs :

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

This Inspection Protocol (IP) was initiated related to a complaint, log #016363-19, that stated staffing levels were reduced and resident care needs were being affected.

A record review of resident #008's written plan of care identified the resident's bathing preference, scheduled days, times and the required number of staff for transfers.

A record review of the 'Follow up Question' report in point of care (POC) for

bathing over an identified four week period revealed the following:
Week 1 - bath day #1- no documentation; bath day #2- bathing documentation by PSW #110.
Week 2 - bath day #1-no documentation; bath day #2 -bathing documentation by PSW #110.
Week 3 - bath day #1 -no documentation; bath day #2- bathing documentation by PSW #110.
Week 4 - bath day #1 - bathing documentation by PSW #111, bath day #2 no documentation, additional bath day- documentation by PSW #110.
Week 5 - bath day #1 - bathing documentation by PSW #110.

An interview with PSW #110 revealed they were unable to provide resident #008 with their scheduled bathing preference and their documentation in the 'Follow Up Question' report was only to acknowledge that a bed bath had been provided. A review of the POC Follow up Question report with PSW #110 revealed that there were four occasions when bed baths were provided and on another occasion where they were unable to complete the resident's bathing preference or bed bath but that they had cleaned the resident's arm pits and peri area. The PSW shared awareness that the resident's SDM would like resident #008 to be bathed, by their bathing preference twice a week but they had insufficient time.

An interview with RN #019 stated that since the staffing changes resident care has been affected including resident's baths and showers. The RN stated that it was now impossible to get everyone bathed twice a week. [s. 33. (1)]

(110)

2. 2. This IP was initiated related to a family concern brought forward by resident #009's SDM to the Inspector during the inspection period.

An interview with resident #009's SDM revealed a concern that their relative, resident #009, had not been receiving their bathing preference for two months. The SDM stated that they would ask resident #009 and they would say no they

had not been bathed and that they could also tell as the resident's hair appeared unclean. The SMD shared that when they visited on an identified date, after the resident's scheduled bathing time they noticed resident #009 smelling of urine and their hair unwashed. The SDM stated they had spoken with the charge nurse who confirmed the resident had not been bathed on the scheduled day and would ensure the resident was bathed the following day.

A record review of the written plan of care identified the resident's preferred date and time of bathing.

An interview with RPN #102 revealed that resident #009's SDM had been involved and communicated that they had noticed a decrease in care to resident #009..

An interview with resident #009 shared that they do miss their bathing and do not like the feeling when they are not clean.

A record review of the POC Follow Up Question Report failed to identify any bathing record for resident #009 over the two identified months the complainant referred to. A review of the resident's health record including progress notes, failed to include documentation of bathes being provided or missed during this two month period.

An interview with RAI coordinator #112 confirmed that resident #009 had not received the minimum if two baths per week over the two identified month period. [s. 33. (1)]

(110)

3. 3. This IP was initiated related to a complaint, log #016363-19 that staffing levels have been reduced and resident care needs affected. As an area of non compliance was identified, the sample size was expanded to include resident #012.

An interview with resident #012's SDM shared that they were concerned that resident #012 was not receiving two bath per week and kept asking the staff to bath the resident. The SDM stated resident #012's hair often looked greasy, was itchy to resident #012 and that their fingernails were often dirty. The SDM stated they left a note in an identified month in the resident's room asking staff to bath and wash the resident's hair twice a week.

A record review of the resident's written plan of care identified that resident's bathing preference days and times and that the resident's nail care was to be provided (clean and trim) on first bath day of the week.

A review of the Follow Up Question Report related to bathing identified four entries over a two month or 8 week period related to bathing. The report did not specify the type of bathing that occurred, tub bath, shower or bed bath and there was no documentation related to the 13 missed baths over the identified eight week period.

An interview with PSW #101 revealed they remembered only bathing the resident one of the two days in two of the four bathing entries and the other day they provided the resident with a bed bath. The PSW shared the documentation in POC does not specify what type of bathing had occurred.

The bathing documentation of August 26, 2019 was documented by PSW #107.

An interview with PSW #107 revealed that they had bathed resident #012 on one of the four identified dates and that there was a note in the resident's night table from the resident's SDM that the resident had not been bathed and could the staff please bath the resident twice a week.

An interview with RAI coordinator #112 confirmed that resident #012 had not received the minimum if two baths per week in the two identified months.

An interview with the DOC shared that a bed bath was not a substitute for the resident's preferred bath or shower. The DOC further shared that when a resident's shower or bath was missed the resident should still be offered their bathing choice the next shift or next day to ensure a minimum of two baths per week. The DOC stated that if there was no documentation of bathing it was

assumed it had not been completed. The DOC confirmed that not all residents had received bathing twice a week. [s. 33. (1)]

The severity of this issue was determined to be a level 1 as there was minimum risk resident #008, #009 and #012.
The scope of the issue was a level 3 widespread as it related to three out of three
residents reviewed.
The home had a level 2 compliance history with one or more unrelated non compliance in the last year. (110)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Order / Ordre :

The licensee must be compliant with the O. Reg 79/10, s. 34 (1).

The licensee is ordered to:
1. Ensure that resident's #007, #006 and #013 receive oral care, including mouth care in the morning and evening, and/or cleaning of dentures.
2. Ensure that all resident's receive oral care, including mouth care in the morning and evening, and/or cleaning of dentures.

Grounds / Motifs :

1. 1. The licensee failed to ensure that the resident receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

This IP was initiated related to complaint, Log #016363-19, whereby the complainant stated that resident #007's care needs, like teeth brushing were not met as a result of changes in staffing levels.

A record review of resident #007's written plan of care identified the resident's oral hygiene care needs; total dependence on staff and directed staff to take time in performing oral care.

During the inspection period at 0847hrs an observation was conducted of resident #007's bathroom to identify if the resident's toothbrush had been used for morning care. The resident was not in their room and the resident's regular toothbrush and toothpaste were identified, labelled with their name. The toothbrush was dry. At 1010hrs the Inspector returned to the resident's room with RPN #102 and confirmed the toothbrush was dry. An observation of resident #007's teeth was completed with the RPN who identified a significant plaque build up on the base of the resident's lower teeth.

PSW #113 was identified as the resident's PSW on same identified day. An interview with PSW #113 confirmed that they provided morning care to resident #007 and that the resident's care was to include teeth brushing. The PSW stated they were unable to brush the resident's teeth as they did not have sufficient time.

An interview with RPN #102 identified that the expectation of staff was to brush the resident's teeth during morning care and that staff had not reported they had not had time. The RPN confirmed the resident had not received oral care in the morning. [s. 34. (1) (a)]

(110)

2. 2. This IP was initiated as a result of non compliance being identified and therefore the sample size was expanded to include resident #006.

A record review of resident #006's written plan of care identified the resident's oral hygiene care needs; total dependence on staff and directed staff to to brush teeth and oral tissues and gums carefully.

During the inspection period at 0847hrs an observation was conducted of resident #006's bathroom to identify if the resident's toothbrush had been used for morning care. The resident was not in their room and the resident's identified toothbrush was observed as dry. At 1010hrs the Inspector returned to the resident's room with RPN #102 and confirmed the toothbrush was dry.

An observation of resident #006's teeth, completed with RPN #102, identified a build up of plaque on the resident's bottom teeth.

PSW #100 was identified as the resident's PSW on the same day. An interview with PSW #100 confirmed they provided morning care to resident #006 and the resident's care was to include teeth brushing. The PSW stated they did not brush the resident's teeth as part of morning care.

An interview with RPN #102 identified that the expectation of staff was to brush the resident's teeth during morning care and that staff had not reported that they had not had time.The RPN confirmed the resident had not received oral care in the morning. [s. 34. (1) (a)]

(110)

3. 3. As a result of non compliance identified in this area the sample size was expanded to include resident #013.

During the inspection at 0900hrs an observation was conducted of resident #013's room to identify if the resident's toothbrush had been used for morning care. The resident was identified asleep in bed. At 1148hrs the Inspector returned to the resident's room with RPN #102 where the resident was not present. The RPN confirmed the resident was in the dining room and that the resident's toothbrush was dry.

PSW #101 was identified as the resident's PSW on the same day. An interview with PSW #101 confirmed they provided morning care to resident #013 and that the resident's care was to included setting the resident up at the sink so the resident could brush their teeth. The PSW stated they did not set the resident up as their was another resident requiring a bath with two staff and they did not have time.

During an interview with RN #110 they stated the home area went from staffing 4 PSW on days to 3 and teeth brushing was one care area to residents that has been affected.

A separate interview with conducted with resident #004, cognitive and totally dependent on staff for care. The resident shared with Inspector that staff do not always brush their teeth in the morning.

An interview with PSW #113 revealed the staffing levels changed from 4 PSWs on days to 3 and lately on average they have two PSW staffed on evenings. The PSW stated that teeth brushing is one care area that has been affected.

An interview with SDM #018 of complaint log #017096-19 shared that care has "dropped like a stone in the last two months" and their resident's oral hygiene has been a problem and staff are not brushing the resident's teeth.

An interview with PSW #113 shared that teeth brushing is one care area that has been affected over the past few months. The PSW stated that they use to brush resident #003 teeth and now they have to swab their teeth and they are down to brushing the resident's teeth once per week.

The licensee failed to ensure that the resident receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures. [s. 34. (1) (a)]

The severity of this issue was determined to be a level 1 as there was minimum risk resident #006, #007 and #013. The scope of the issue was a level 3 widespread as it related to three out of three
residents reviewed. The home had a level 2 compliance history with one or more unrelated non compliance in the last year.
(110)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 the LTCHA, 2007, s. 6 (7).

The licensee is ordered to:
1. Ensure that resident's #001, #007 and #004 are provided the opportunity to eat their meals in the dining room according to their plan of care.
2. Ensure that all resident's are provided the opportunity to eat their meals in the dining room as specified in their plan of care.

Grounds / Motifs :

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

This IP was initiated related to resident #001's SDM who had expressed a concern to the Inspector during the inspection. The SDM shared their had been a lot of staffing cuts l in the home and the care to resident #001 had been affected.

During the interview, the SDM stated that on an identified day resident #001 did not get up for breakfast and the resident's breakfast tray was still in the resident's room late afternoon when they arrived to visit. The SDM stated that resident #001 was upset they did not get up for breakfast as they looked forward to going to the dining room. The SDM shared that they were informed by the RPN that they were short staffed during the day shift with only two PSWs.

An interview with PSW #114 confirmed they worked on the identified weekend revealed in the SDM's concern and worked short one PSW. The staff shared that resident #001 did not get up two days in a row for breakfast as they did not

have time to get the resident up. The PSW stated that the resident normally goes to the dining room and on an identified date the resident shared with the PSW that they really wanted to get up and go to the dining room.

An interview with PSW #111 confirmed they worked the identified weekend they did work short. The staff could not recall resident #001 by name but stated their were residents who staff were unable to get up for breakfast in the dining room.

An interview with RPN #115 confirmed they worked the same identified weekend and that there were residents staff were unable to get up into the dining room for breakfast and that tray service was provided.

The licensee failed to ensure that care set out in resident #001's plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

(110)

2. 2. This IP was initiated related to complaint, log #016363-19, whereby the complainant stated that resident #007's care needs, like getting up into the dining room for breakfast were not being met, as a result of changes in staffing levels.

In separate staff interviews, PSW #116 and PSW #104 stated that they were unable to get resident #007 up for breakfast in an identified morning during the inspection . PSW #116 stated the resident normally eats in the dining room, was last on their list to get ready and they ran out of time.

An interview with RPN #102 confirmed that there are times when staff are unable to get residents up who normally go to the dining room for breakfast.
(110)

3. 3. This IP was initiated related to complaint log, #016363-19, revealing concerns of insufficient staffing and resident care needs not being met. As a result of non-compliance being identified the sample size was expanded to resident #004.

A record review was completed of resident #004's written plan of care which identified resident #004 requiring total assistance with eating and transfers. The written plan of care stated the resident's preference for when and where to have meals and be placed back to bed.

An interview with resident #004, observed sitting in their chair one hour after the time identified in the resident's plan of care directs staff to place the resident in bed. The resident shared that over the past few months staff have been unable to accommodate their preference of meal location and bed rest schedule. The resident share their personal desire of why they liked to go to the dining room.

An interview with PSW #100 confirmed that staff were sometimes unable to get resident #004 up for an identified meal as they could not commit to placing them back to bed in the afternoon so the resident often agreed to stay in bed. A further interview with RPN #102 shared that resident #004 does not usually get up for an identified meal as sometimes the PSWs do not have time. The RPN shared that the resident's plan of care was not followed as their preference for getting up and going back to bed was not followed.

An interview with the DOC shared that the resident's plan of care would not have been followed if the staff did not provide the opportunity for the residents to go to the dining room for meals as specified in their plan. [s. 6. (7)]

The severity of this issue was determined to be a level 1 as there was minimum risk resident #004, #007 and #001
The scope of the issue was a level 3 widespread as it related to three out of three residents
reviewed.
The home had a level 3 compliance history with one or more related non compliance in the three years that included:
- Written notification (WN) issued December 20, 2017 in report #2017_462600_0019.
- Voluntary plan of compliance (VPC) issued December 11, 2018 in report #2018_684604_0019
- VPC issued June 26, 2019 in report #2019_516734_0003.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

(110)

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

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

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