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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 13, 2016	2016_188168_0015	018782-16	Resident Quality Inspection

Licensee/Titulaire de permis

PARKVIEW MEADOWS CHRISTIAN RETIREMENT VILLAGE
72 Town Centre Drive Townsend ON N0A 1S0

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

GARDENVIEW LONG TERM CARE HOME
72 Town Centre Drive Townsend ON N0A 1S0

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

LISA VINK (168), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 23, 24, 28 and 29, 2016.

The following concurrent inspections were conducted during the course of this RQI.

Complaint - 016628-16 - related to nursing and personal support services, bathing, training and orientation
Critical Incident - 031583-16 - related to transferring and positioning techniques and following manufacturer's instructions

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer/Director of Care (CEO/DOC), Assistant Director of Care (ADOC), Medical Director, Controller, Assistant Controller, Recreation Manager, Director of Environmental Services (DES), Physiotherapist, maintenance staff, registered nursing staff, personal support workers (PSW), retirement home staff, families and residents.

During the course of the inspection, the inspectors observed the provision of care and services, reviewed relevant polices and procedures, accessed College of Nurses of Ontario - Find a Nurse database, reviewed investigative notes, reviewed staffing schedules, reviewed meeting minutes and clinical records as required.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

11 WN(s)
8 VPC(s)
1 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	Legendé 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. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all persons hired on or after January 1, 2016, to provide personal support services, regardless of title, had successfully completed a personal support worker program that met the requirements.

Interview with the CEO/DOC identified that on the rare occasion when the long term care home (LTCH) was not able to fill vacant PSW and as a result did not work with the full desired staffing complement, staff from the retirement home would assist residents in the LTCH with non-nursing duties such as feeding and transporting residents on the second floor.
Interview with registered staff #200 and PSW #210 confirmed situations where retirement home staff worked shifts in the LTCH and reported that they assisted in the provision of personal care.
Identified retirement home staff who provided care to LTCH residents included staff #206 and #213.
Staff #206 and #213 were interviewed and confirmed that they were retirement home staff, had not completed a PSW program nor registered nursing program and worked shifts in the LTCH on occasions. The staff identified that when they were in the LTCH, they consistently worked with a LTCH PSW and provided care including but not limited to: distribution of nourishment, provision of feeding assistance, transportation of residents, positioning of residents to allow for the provision of care such as continence changes, provision of or assistance with oral care and provision of assistance with the guiding and/or moving the mechanical lift which was being operating by the LTCH staff to transfer residents.
The Time-Earnings Report provided by the home identified that staff #206 worked in the LTCH as a PSW on January 3, 16, and 17, 2016, March 12, 2016 and April 30, 2016.
The Time-Earnings Report provided by the home identified that staff #213 worked in the LTCH as a PSW on December 22, 24, 29, and 30, 2015 and January 17, 2016.
Not all staff who were hired to provide personal support services to residents in the LTCH successfully completed a PSW program. [s. 47. (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. 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required it.

Interview with the CEO/DOC confirmed the expectation that an assessment be completed when a resident had a change in continence, in addition to the MDS assessment. Discussion with the ADOC confirmed an assessment was to be conducted when a resident had a change in continence.
A. Resident #101 was identified during the MDS assessment dated November 17, 2015, to be continent of bowel functioning. During the next assessment dated February 9, 2016, the resident was noted to be occasionally incontinent of bowel. A review of the only additional documents related to continence completed were the Tena Incontinence Management System - New Admission and Product Change Form and not an assessment instrument that was specially designed for the assessment of incontinence. The ADOC confirmed that resident #101 did not have an assessment conducted, using a clinically appropriate assessment instrument that was designed for the assessment of incontinence.
B. Resident #106 was identified during the MDS assessment dated September 29, 2015, to be continent of bladder functioning, during the next assessment dated December 22, 2015, they were identified to be occasionally incontinent of bladder and during the March 15, 2016, assessment noted to be frequently incontinent of bladder. Staff interviewed on June 28, 2016, identified that the resident was not continent and was no longer toileted. A review of the only other documents completed related to continence were the Tena Incontinence Management System - New Admission and Product Change Form and not an assessment instrument that was specially designed for the assessment of incontinence. Interview with the ADOC confirmed that resident #106 did not have an assessment conducted, using a clinically appropriate assessment instrument that was designed for the assessment of incontinence.
Residents who were incontinent did not receive an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, nor an assessment conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required it. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident requires, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there was a written description of the program that included goals and objectives.

A. A review of the home's programs for Restraints, Personal Assistance Service Devices (PASD's) and Skin and Wound Care confirmed that there were no written descriptions for the programs which included goals and objectives. Interview with the ADOC on June 29, 2016, confirmed that these programs did not include goals and objectives as required, that this was completed on an informal basis only. (506)
B. A request was made for the home's Continence Care and Bowel Management Program to the CEO/DOC and ADOC. The home provided a Continence procedure last revised July 2013, which did not include goals and objectives. Interview with the ADOC identified that the current procedure in place required revision and that plans were currently in place to have this completed. She confirmed that current program did not include documented goals and objectives nor the assessment tools currently available in the home for staff to use when a resident displayed a change in continence. [s. 30. (1) 1.]

2. The licensee failed to ensure that they kept a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of changes made and the date that those changes were implemented.

The ADOC indicated that the home had not completed a formal written record relating to each evaluation of the required programs including: Skin and Wound Care, Continence Care and Bowel Management and Minimizing of Restraints. [s. 30. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there is a written description of the program that includes goals and objectives and to ensure that they keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participate in the evaluation, a summary of changes made and the date that those changes are implemented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of their choice or more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A. According to the bath schedule resident #102, was to be bathed on September 19, 2015 and June 25, 2016. A review of Point of Care (POC) records indicated that bathing was documented as 'not applicable' on September 19, 2015 and there was no reference to the provision of bathing on June 25, 2016.
B. According to the bath schedule resident #103, was to be bathed on September 19, 2015 and June 25, 2016. A review of POC records indicated that bathing was documented as 'not applicable' on September 19, 2015 and there was no reference to the provision of bathing on June 25, 2016.
C. According to the bath schedule resident #105, was to be bathed on September 19, 2015 and June 25, 2016. A review of POC records indicated that bathing was documented as 'not applicable' on September 19, 2015 and there was no reference to the provision of bathing on June 25, 2016.
D. According to the bath schedule resident #106, was to be bathed on September 19, 2015, October 4, 2015 and June 25, 2016. A review of POC records indicated that bathing was documented as 'not applicable' for September 19, 2015 and there was no reference to the provision of bathing on October 4, 2015 or June 25, 2016.
During an interview with the ADOC it was confirmed that the home did not work with the full desired staffing complement on the identified dates and bathing was not completed. Interview with PSW #221 verified that the home did not work with the full desired staffing complement of PSW staff on June 25, 2016 and bathing was not completed for the residents. [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 to ensure that the residents are bathed, at a minimum, twice a week by the method of their choice or more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the policy and procedure for call bell response / pager system was complied with.

The home's policy "Call Bell Response/Pager System, Nursing Manual, Section: Care, last revised August 2015", indicated that when pagers, which activated with an auditory alarm when a call bell was pulled, were not functioning properly maintenance should be promptly notified. Staff were directed to check the batteries in the pagers, which were to be available at nursing station and medication room. If the issue with the pagers persisted a maintenance requisition, which was located at the nursing station, should be filled out and submitted to the DES.

On June 29, 2016, PSW's #210 and #211 confirmed that they did not have a pager with them and PSW #209 had a pager that was missing a battery cover and as a result was "sensitive". The PSWs identified when questioned that their pagers were not working and that this was ongoing for approximately three weeks. RPN #200 verified that the pagers were in the nursing station as they were not working. Maintenance staff were notified of the issue immediately at the request of the Inspector. Following a review of the identified pagers and some trouble shooting maintenance staff #220 identified that the pagers that were reported on June 29, 2016, to be not working, only required battery replacement. Maintenance staff #220 confirmed that there were batteries available to the staff on the unit, which was observed by the Inspector. Maintenance staff #220 and the DES identified that they were unaware of any issues with the pagers as they did not receive a maintenance requisition regarding the concern. Maintenance staff verified that there was a sufficient supply of pagers, replacement parts and batteries in the home should a pager require repair or replacement.
The policy and procedure for call bell response / pager system was not complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On April 5, 2016, resident #100 had an area of altered skin integrity, a pressure area, identified. Registered staff #200 and documentation review confirmed the resident's skin was not assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when the altered skin was identified.
The resident with altered skin integrity did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

A. Resident #100 had a history of a recurring pressure ulcer. The area of altered skin integrity was noted on an identified date in April 2016. Interview with registered staff #200 confirmed the clinical record did not include a reassessment of the area of altered skin integrity at least weekly by a member of the registered nursing staff. The resident had dressings applied to the area in April 2016, until the area was healed in May 2016; however, registered staff #200 confirmed the area was not reassessed weekly as required.
B. Resident #104 was admitted to the home with a number of areas of altered skin integrity which although treated did not heal. The areas were not reassessed at least weekly, as required, by nursing staff as confirmed with registered staff #200 on June 29, 2016. During the two month time period of April and May 2016, the resident was not reassessed on three occasions as required to ensure a weekly skin assessment.
Residents with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were not reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and that the resident with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the licensee was subject.

Section 4.0 under Schedule B of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, reads, "The Health Service Provider shall use the funding allocated for an Envelope for the use set out in the Applicable Policy". The Long-Term Care Homes Funding Policy of July 1, 2010, for Eligible Expenditures for Long-Term Care Homes Nursing and Personal Care (NPC) Envelope Section 1. b) reads, "Direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene services, administration of medication, and nursing care."

In separate interviews the CEO/DOC and ADOC identified that it was the role of the ADOC to complete human resource activities for the attached retirement home. These activities included but were not limited to hiring, directing and scheduling staff of the retirement home. Interview with Controller, which was confirmed by the CEO/DOC, identified that 100% of the ADOC wages were taken from the NPC funding envelope for the LTCH. The CEO/DOC identified that the retirement home previously had a Manager in place. This position became vacant in approximately December 2015 and since this time the ADOC was responsible for human resource tasks in the retirement home, which require approximately four hours a month.
The licensee did not comply with the conditions to which the licensee was subject when they used funds from the NPC envelope to compensate the ADOC for time spend managing the retirement home. [s. 101. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that they comply with the conditions to which the licensee is subject, to be implemented voluntarily.

WN #8: 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 that the staffing plan included a back-up plan for nursing and personal care that addressed situations when staff could not come to work, including 24 hour registered nurse (RN) coverage or was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A request was made of the CEO/DOC and ADOC for the nursing and personal care staffing plan, back up plan and evaluation of the staffing plan.
The home provided a copy of the Daily Shift Report for Birch Trail and Willow Grove which detailed the type of staff and the hours to be worked over a 24 hour period on each unit; however, this document did not include a plan to ensure that resident care needs were met if the home was in a situation where staff could not come to work.
A copy of the "Call In Procedure - 24 Hours a Day" was provided as the back up plan. This procedure did not address situations when staff could not come to work, how to ensure resident care needs were met at these times, nor a specific reference to 24 hour RN coverage. Discussions held with the CEO/DOC and ADOC identified that the home had an informal process in place; however, was not documented and direction was usually provided on a case by case basis by the CEO/DOC based on the situation at the time when a back up plan was needed.
It was verified by a number of staff that there had been occasions as recently as in the past month that the home worked without the full desired staffing complement for both PSW and registered nursing staff.
The CEO/DOC and ADOC confirmed during separate interviews that the home's staffing needs were reviewed and evaluated on an as needed basis, usually driven due to issues communicated by front line staff. The CEO/DOC and Controller would then review the staffing and budget allocation and changes would be implemented based on the identified needs as appropriate. It was identified that this process, although discussed at nursing team meetings, was informal and the home was not able to produce a copy of the evaluation of the staffing plan when requested.
The staffing plan did not include a back-up plan for nursing and personal care that addressed situations when staff could not come to work, including 24 hour RN coverage nor was it evaluated and updated at least annually in accordance with evidence-based practices and if there were none, in accordance with prevailing practices. [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 that the staffing plan includes a back-up plan for nursing and personal care that addresses situations when staff can not come to work, including 24/7 RN (registered nurse) coverage and is evaluated and updated at least annually in accordance with evidence-based practices and if there are none, in accordance with prevailing practices., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of the resident's continence, including bowel elimination.

Resident #106 was identified in the Minimum Data Set (MDS) assessment, completed March 15, 2016, as usually continent of bowels. The Tena Incontinence Management System - New Admission and Product Change Form, dated May 25, 2016, identified the resident was incontinent of stool. PSW staff #210 and #211 identified that due to a change in condition the resident was now incontinent of bowel which was confirmed during an interview with registered nursing staff #200. A review of the plan of care in place on June 29, 2016, did not include a focus statement related to bowel functioning as confirmed with registered staff #200 and the Resident Assessment Instrument (RAI) Coordinator during a review of the plan of care.
The resident's plan of care was not based on an interdisciplinary assessment of the resident's continence, including bowel elimination. [s. 26. (3) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's plan of care is based on an interdisciplinary assessment of the resident's continence, including bowel elimination, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, 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).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Resident #106 was identified during the MDS assessment dated March 15, 2016, as frequently incontinent of bladder. The Resident Assessment Protocol (RAP) completed for the same assessment identified the resident as occasionally incontinent of bladder. Interview with registered staff #200 and the RAI Coordinator, who reviewed the assessment and RAP confirmed that the documents were not consistent and did not complement each other for the continence status of the resident.
Staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the documentation included every release of the device and repositioning.

Resident #105 had a device in place which was considered a restraint as per the physician's order. On June 24, 2016, the resident was observed and was noted to be checked, the device removed and the resident repositioned as required. A review of the POC documentation related to the release of the device and repositioning of the resident from May 30, 2016 until June 29, 2016, did not consistently include the documentation of the provision of care every two hours as required, during the 30 day period, as confirmed during an interview with the ADOC.
The documentation related to the use of a restraint did not included every release of the device and repositioning. [s. 110. (7) 7.]

Issued on this 8th day of August, 2016

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

Ministére 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) :	LISA VINK (168), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2016_188168_0015
Log No. / Registre no:	018782-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 13, 2016
Licensee / Titulaire de permis :	PARKVIEW MEADOWS CHRISTIAN RETIREMENT VILLAGE 72 Town Centre Drive, Townsend, ON, N0A-1S0
LTC Home / Foyer de SLD :	GARDENVIEW LONG TERM CARE HOME 72 Town Centre Drive, Townsend, ON, N0A-1S0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARA DI BIASE

To PARKVIEW MEADOWS CHRISTIAN RETIREMENT VILLAGE, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order / Ordre :

The licensee shall ensure that all staff persons hired and those hired since January 1, 2016, who provide personal support services, regardless of title, have successfully completed a personal support worker program which meets the requirements of the regulations. This compliance order includes all full time, part time, casual and relief staff who provide care to personal care to residents in the long term care home, regardless of their employment status with the licensee.

Grounds / Motifs :

1. This Compliance Order is served based upon the application of the factors of severity, scope and compliance history in keeping with O. Reg. 79/10 LTCHA., 2007, s. 47(1):
in respect to severity there was minimal harm/risk or potential for actual harm/risk,
in respect to scope the situation was a pattern, and
in relation to history the licensee had previous unrelated non-compliance in the last three years.

The licensee failed to ensure that all persons hired on or after January 1, 2016, to provide personal support services, regardless of title, had successfully completed a personal support worker program that met the requirements.

Interview with the CEO/DOC identified that on the rare occasion when the long term care home (LTCH) was not able to fill vacant PSW and as a result did not

work with the full desired staffing complement, staff from the retirement home would assist residents in the LTCH with non-nursing duties such as feeding and transporting residents on the second floor.
Interview with registered staff #200 and PSW #210 confirmed situations where retirement home staff worked shifts in the LTCH and reported that they assisted in the provision of personal care.
Identified retirement home staff who provided care to LTCH residents included staff #206 and #213.
Staff #206 and #213 were interviewed and confirmed that they were retirement home staff, had not completed a PSW program nor registered nursing program and worked shifts in the LTCH on occasions. The staff identified that when they were in the LTCH, they consistently worked with a LTCH PSW and provided care including but not limited to: distribution of nourishment, provision of feeding assistance, transportation of residents, positioning of residents to allow for the provision of care such as continence changes, provision of or assistance with oral care and provision of assistance with the guiding and/or moving the mechanical lift which was being operating by the LTCH staff to transfer residents.
The Time-Earnings Report provided by the home identified that staff #206 worked in the LTCH as a PSW on January 3, 16, and 17, 2016, March 12, 2016 and April 30, 2016.
The Time-Earnings Report provided by the home identified that staff #213 worked in the LTCH as a PSW on December 22, 24, 29, and 30, 2015 and January 17, 2016.
Not all staff who were hired to provide personal support services to residents in the LTCH successfully completed a PSW program. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

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 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 13th day of July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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