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 # / No de registre	Type of Inspection / Genre d'inspection
May 25, 2018	2018_703625_0007	001520-18, 001524-18, 001531-18, 001533-18, 005318-18, 005320-18, 005321-18, 005322-18, 005327-18	Follow up

Licensee/Titulaire de permis

Riverside Health Care Facilities Inc.
110 Victoria Avenue FORT FRANCES ON P9A 2B7

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

Rainycrest
550 Osborne Street FORT FRANCES ON P9A 3T2

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

KATHERINE BARCA (625), AMY GEAUVREAU (642), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 17 to 20 and 23 to 27, 2018.

This Follow-up inspection was conducted to inspect on the following intakes:
- a log related to CO #001 from inspection #2017_624196_0016 pursuant to s. 6. (7) plan of care;

- a log related to CO #002 from inspection #2017_624196_0016 pursuant to s. 15. (2) accommodation services - maintenance;
- a log related to CO #003 from inspection #2017_624196_0016 pursuant to r. 48 (1) skin and wound program;
- a log related to CO #001 from inspection #2017_624196_0016 pursuant to s. 19 (1) prevention of abuse and neglect;
- a log related to CO #005 from inspection #2018_509617_0004 pursuant to r. 229 (6) Infection Prevention and Control Program (IPAC) hand hygiene program;
- a log related to CO #003 from inspection #2018_509617_0004 pursuant to s. 229 (9) IPAC analysis and review;
- a log related to CO #004 from inspection #2018_509617_0004 pursuant to s. 229 (7) IPAC surveillance protocols;
- a log related to CO #001 from inspection #2018_509617_0004 pursuant to r. 31 (3) regarding the home's staffing plan; and
- a log related to CO #002 from inspection #2018_509617_0004 pursuant to r. 219 (4) training and retraining staff regarding IPAC;

Critical Incident System (CIS) inspection #2018_703625_0008 and Complaint inspection # 2018_703625_0009 were conducted concurrently with this Follow up inspection.

A finding of non-compliance related to the Long-Term Care Homes Act (LTCHA), 2007, s. 6 (9) 1, identified during the CIS inspection was issued in this Follow up inspection.

Findings of non-compliance related to the LTCHA, 2007, s. 6. (7) and Ontario Regulation 79/10, s. 36, identified during the Complaint inspection were issued in the Follow up inspection.

During the course of the inspection, the inspector(s) spoke with residents, families, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Resident Assessment Instrument (RAI) Coordinator, an Infection Control Practitioner (ICP), a Public Health Inspector, representatives from the Ontario Nurses Association, an Administrative Assistant, a Ward Clerk, a Receptionist, a Financial Services employee, a Physiotherapy Assistant, Physiotherapists, the Activity Coordinator, the Assistant Director of Care (ADOC), the Director of Resident Care (DOC), the Manager of Maintenance, the Director of Engineering and the Administrator.

The Inspectors also conducted daily tours of the resident care areas, observed the provision of care and services to residents and observed staff and resident interactions. The Inspectors also reviewed residents' health care records, training records, staffing documents, and licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #002	2017_624196_0016	642
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #004	2017_624196_0016	625
O.Reg 79/10 s. 229. (6)	CO #003	2018_509617_0004	642
O.Reg 79/10 s. 229. (7)	CO #004	2018_509617_0004	642
O.Reg 79/10 s. 229. (9)	CO #005	2018_509617_0004	642
O.Reg 79/10 s. 31. (2)	CO #001	2018_509617_0004	625
O.Reg 79/10 s. 48. (1)	CO #003	2017_624196_0016	642

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Compliance order (CO) #001 was issued from inspection #2018_509627_0004 pursuant to Ontario Regulation 79/10, s. 31. (3) (a). The order required the home to develop, implement and maintain records for an auditing process to ensure that when working short staffed, all resident care that was missed was followed up with. The grounds in the order identified that staff shortages had impacted the provision of bathing to residents.

Inspector #625 reviewed the document titled Bath Schedule Days for resident #010 that identified the resident had a bath scheduled at a specified frequency on particular days of the week.

A review of resident #010's ADL Assistance care plan, last updated in the winter of 2018, identified that the resident required the use of transfer equipment and the assistance of staff to transfer and to bathe. The care plan did not indicate the type of bath the resident preferred or required.

The PSW Flow Sheet identified that resident #010 had a particular type of bath on three dates in April 2018.

A review of GoldCare progress notes did not identify any notes corresponding to the provision of the particular type of bath provided to resident #010 on the three dates in April 2018.

During an interview with Personal Support Worker (PSW) #128, they stated that residents who required a specific type of equipment to transfer were given a particular type of bath, instead of another type of bath, when the unit worked short staffed.

A review of a spreadsheet titled Nursing Shortage Hours identified that the home was short PSWs on the three dates in April 2018.

During an interview with Inspector #625, the Assistant Director of Care (ADOC) stated that they were not sure what kind of a bath resident #010's was supposed to have and did not know if the resident's preference was to have the type of bath they had been provided with on the three dates in April, although the resident's last three baths had been recorded as that particular type of bath. The ADOC reviewed the resident's care plan and stated that the care plan was not clear to staff as to what type of bath the resident wanted. [s. 6. (1) (c)]

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

CO #001 was issued from inspection #2017_624196_0016 pursuant to the Long-Term Care Homes Act (LTCHA), 2007 S.O. 2007, c.8, s. 6. (7).

The licensee was ordered to:
a) Ensure skin and wound care is provided to resident #014, and to all residents in the home, as specified in their plans of care;
b) Ensure that:
1) resident #005 is provided with bathing and transferring specific to their designated plan of care,
2) resident #006 is provided with the interventions specified within their plan of care to manage their responsive behaviours,
3) resident #004 is provided with transferring techniques, as specified in their respective plan of care, and

c) Ensure that all resident care, set out in the plan of care, is provided to the resident as specified in the plan.

The compliance date was February 28, 2018.

The licensee completed section a) in ensuring that resident #014 was provided with skin and wound care; and areas of section b) in ensuring resident #004 was provided with transferring techniques specific to their care plan.

The licensee failed to complete areas of section b) in ensuring that resident #005 was provided with bathing and resident #006 was provided with responsive behaviour interventions specific to their plans of care.

Inspector #617 reviewed resident #005’s care plan last updated in the winter of 2018, which identified that the resident required staff assistance with transferring and bathing, using transfer equipment.

A review of the documentation of the care provided to resident #005, specific to bathing, on their PSW Flow Sheet, indicated that between two dates in the spring of 2018, over a period of ten days, the resident received one bath.

A review of the unit's bath schedules indicated that resident #005 was scheduled to receive their bath on particular shifts twice weekly. The resident had received one bath during this period of ten days.

A review of the Head to Toe Assessment completed by the PSWs did not indicate that the resident had refused a bath over multiple days within the ten day period.

In an interview with resident #005 they reported to the Inspector that they have baths at a particular frequency on two specific days of the week, depending on the staffing. The resident reported that in April they had missed their a bath because the unit was short staffed. The resident explained that they relied on staff assistance to bathe.

During interviews with PSWs #148 and #149, they reported to the Inspector that resident #005 was scheduled to have their baths at a particular frequency on specific shifts. Both PSWs reported that resident #005 required assistance from staff with bathing activities. PSW #149 confirmed to the Inspector that on a date in April 2018, resident #005 had missed their bath on a shift due to short staffing on the unit. The PSW further explained

that the contingency plan required the following shift on that date to provide the missed bath, however; the unit was short staffed on the following shift and was unable to provide the bath.

In an interview with Receptionist #135 they confirmed to Inspector #617 that on a particular date in the spring of 2018, the unit worked with multiple PSWs shortages on two particular consecutive shifts.

In an interview with the Director of Care (DOC), both the Inspector and the DOC reviewed resident #005's flow sheet and Head to Toe Assessments. The DOC confirmed that resident #005 had missed a bath, and was not provided with their scheduled bath as specified in their plan of care. [s. 6. (7)]

3. CO #001 was issued from inspection #2017_624196_0016 pursuant to the LTCHA, 2007 S.O. 2007, c.8, s. 6. (7). Part b) of the order directed the home to ensure that resident #006 was provided with the interventions specified in their plan of care to manage their responsive behaviours, with a compliance date of February 28, 2018.

The licensee failed to complete areas of section b) in ensuring that resident #006 was provided with responsive behaviour interventions specific to their plan of care.

Inspector #617 reviewed resident #006's care plan dated a particular date in the winter of 2018, which indicated that the resident exhibited responsive behaviours related to a medical diagnosis and specific characteristics exhibited. A description of the behaviours and triggers were identified in the care plan. Interventions indicated that the staff who provided a particular type of staffing were to document, at a specific frequency, the resident's responsive behaviours on the resident's health care record to capture behavioural triggers.

A review of resident #006's physician's orders dated the fall of 2017, identified that the staff were to track the resident's behaviours on the resident's health care record at a specific frequency, and a particular level of staffing was to be provided, due to an interaction involving another resident that had occurred.

In an interview with PSW #150 they reported that, according to resident #006's care plan and physician's orders, staff who provided the particular level of staffing were required to document the resident's behaviours at a specified frequency. The PSW further explained that resident #006's behaviours were to be documented in a two specific locations in the

resident's health care record.

Inspector #617 reviewed the schedule of the ordered staffing level provided to resident #006 over 55 days in the winter to spring of 2018, which identified that the resident did receive the ordered staffing level during that period of time.

A review of resident #006's PSW Flow Sheet documentation, dated from the winter to the spring of 2018, identified that 30 per cent of the shifts requiring behavioural documentation had not been completed by staff providing the ordered staffing level as per the plan of care.

A review of an additional document in resident #006's health care record, dated from the winter to the spring of 2018, identified that 18 per cent of the shifts did not contain the required documentation by the staff who had provided the ordered level of staffing to resident #006.

In an interview with the DOC, the DOC reviewed resident #006's documentation of their behaviours and confirmed that the staff who provided the ordered level of staffing were required to document the resident's behaviours, and documentation was missing where the staff failed to provide the care as set out in the plan of care. [s. 6. (7)]

4. CO #001 was issued from inspection #2018_509627_0004 pursuant to Ontario Regulation 79/10, s. 31. (3) (a). The order required the home to develop, implement and maintain records for an auditing process to ensure that when working short staffed, all resident care that was missed was followed up with, with a compliance date of April 15, 2018.

Inspector #625 reviewed an ONA/Long-Term Care Professional Responsibility (PRW) Report Form which detailed that, due to staffing shortages, on a particular date in April 2018, over a specific shift, "All treatments not completed on both [two units]". The document identified that, on that date, the home:
- had one Registered Nurse (RN) [from a complement of 2] over four hours during the shift;
- was short six PSWs on the previous shift [from a complement of 14 full and two partial shifts], had two PSWs on one unit for four hours [from a complement of five full shifts and one partial shift], had two PSWs on another unit for the entire shift [from a complement of four PSWs]; and
- did not have a Registered Practical Nurse (RPN) show up for work at a particular time

[from a complement of five RPNs].

The Inspector reviewed a spreadsheet titled Nursing Shortage Hours which identified the home was short 11.25 RN/RPN hours and 60 PSW hours on that particular date in April 2018.

The Inspector reviewed the Rainycrest Wound Auditing Sheet for one unit for one week in April 2018, which had been completed five days after the audited week had ended, by RN #130, the home's Skin and Wound Care Lead. The audit identified that one weekly progress note was missing for resident #007, but did not identify any other missed treatment components.

Inspector #625 reviewed the Treatment Record – Long Term Care for resident #012 which identified, with respect to the resident's altered skin integrity, the RN was to complete an intervention at a specific frequency on a particular day of the week. The corresponding evaluation notes did not include an entry for a particular date in April 2018, and the resident's GoldCare progress notes did not contain any documentation on the intervention that was to have occurred on that date.

The Inspector also reviewed resident #013's Treatment Record – Long Term Care which identified the resident's area of altered skin integrity required an intervention to be completed at a specified frequency. The corresponding evaluation notes did not include entries reflecting the intervention had been completed on three particular dates in April 2018.

During an interview with the home's Skin and Wound Care Lead, RN #130, they stated that staff were required to document daily on the Treatment Record – Long Term Care form and weekly in a GoldCare progress note. The RN indicated that a lack of completion of wound care would be evident on the treatment record. The RN acknowledged resident #012's treatment record did not contain documentation that an intervention was completed on a date in April 2018, and resident #013's treatment record did not include a note for the required intervention on three dates in April 2018. The RN identified that the treatments had not been completed if a corresponding note was not present on the treatment record.

During an interview with Inspector #625, the ADOC stated that RN #130 completed the skin and wound care audits. The ADOC acknowledged that, as the RN had not completed an audit for missed skin and wound treatment related care for one particular

week in April until five days after the week ended, the RN would not be able to go back and ensure that resident care that was missed was followed up with and completed as required. The ADOC also acknowledged that the missed intervention for resident #012 on a date in April, had not been identified during the audit that occurred by the RN, as that date had not yet been audited with an opportunity to address deficiencies in resident care not completed due to staffing shortages. [s. 6. (7)]

5. A complaint was received by the Director regarding a fall experienced by resident #005.

Inspector #625 reviewed resident #005's electronic progress notes which identified the resident multiple times, while using a mobility aid, in the winter and spring of 2018. A note related to the fall in the spring of 2018, identified that the resident's care plan indicated the resident required a falls prevention item to be used when using their mobility aid, but that the item had not been utilized.

Inspector #625 reviewed resident #005's care plan titled Falls, last updated in the spring of 2018. The care plan contained an intervention dated several years prior, that identified the resident required the falls prevention item when using their mobility aid. The care plan also included an intervention entered the day after their fall in the spring of 2018, that identified the resident was issued another falls prevention item to use with their mobility aid as they did not have one in place.

During an interview with RN #114, they stated that resident #005's falls usually occurred when using their mobility aid in a specific manner. The RN acknowledged that the resident's care plan identified that they required the falls prevention item over the last few years, but the progress notes identified that the item was not in use with the mobility aid when the resident fell in the spring of 2018. The RN stated that care set out in resident #005's care plan was not provided to the resident with respect to the use of the falls prevention item with their mobility aid.

During an interview with Inspector #625, the DOC stated that, according to resident #005's care plan and progress notes, they did not have the falls prevention item in use with their mobility aid when they fell in the spring of 2018, but required one. The DOC acknowledged that resident #005 did not have the care set out in their plan of care provided, with respect to the use of the falls prevention item with their mobility aid. [s. 6. (7)]

6. The following is further evidence to support CO #001 issued on January 10, 2018, during RQI #2017_624196_0016, with a compliance due date of February 28, 2018. Grounds supporting CO #001 were identified specifically related to resident #005 being transferred in a manner other than that detailed in their care plan.

A complaint was received by the Director related to alleged abuse and neglect of resident #005.

Inspector #625 reviewed a Critical Incident System (CIS) report that identified that resident #005 requested the assistance of the home's staff multiple times over a period of time before PSW #124 assisted the resident.

The home's investigation file identified that PSW #124 had transferred resident #005 in an unsafe manner. The alleged incident occurred several weeks after the home was served CO #001 in the above mentioned report, which included supportive grounds for resident #005 being transferred in a manner other than that detailed in their plan of care.

A review of the resident #005's ADL Assistance care plan identified that the resident required staff assistance to transfer.

During an interview with Inspector #625, the DOC stated that PSW #124 assisted resident #005 to transfer in a manner other than that detailed in the resident's care plan. The DOC acknowledged that the home had a current order from inspection report #2017_624196_0016 related to resident #005's transferring and that the care set out in resident #005's plan of care had not been provided to the resident, with respect to transferring the resident, at the time of the incident. [s. 6. (7)]

7. A complaint was received by the Director regarding the care of resident #002. The complaint alleged that toileting was not being provided as per the resident's plan of care due to staffing shortages.

During an interview with Inspector #617, the complainant reported that they witnessed resident #002 wait for a prolonged period of time to be assisted to the toilet. The complainant explained that the resident required the assistance of staff and was not able to toilet themself.

A review of resident #002's care plan dated the winter of 2018, indicated that the resident required the assistance of staff with toileting at a specific frequency, and that staff were

to document the care provided on a document initiated in the spring of 2018.

Inspector #617 reviewed the document listing the dates and times the resident was to be toileted, and instructions for staff to record when the resident was toileted, on the document. The documentation indicated that, over a period of 12 days in the spring of 2018, documentation of resident #002's toileting was missing 61 per cent of the time,

During interviews with RPN #129 and PSWs #147 and #146, they confirmed to the Inspector that resident #002 required staff assistance with a component of toileting, was to be toileted at a particular frequency and staff were to record the toileting on the document in use. In a separate interview with PSW #147, they reported that when the unit was short staffed, there was not enough staff to provide the required staff assistance to the resident and, as a result, the resident's toileting may have been missed at the required frequency.

In an interview with the DOC, they reviewed the document detailing resident #002's toileting over the 12 day period and confirmed to the Inspector that there were several times documentation was missing, which indicated that the staff were not following the resident's care plan and toileting the resident at the required frequency. [s. 6. (7)]

8. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Compliance order #001 was issued from inspection #2018_509627_0004 pursuant to Ontario Regulation 79/10, s. 31. (3) (a). The order required the home to develop, implement and maintain records for an auditing process to ensure that when working short staffed, all resident care that was missed was followed up with.

Inspector #625 reviewed a particular unit's PSW Assignment binder #2 with a focus on beverage and snack provision from April 15 to the day shift on April 26, 2018. The Inspector noted there was an absence of documentation identifying that snack/beverages were provided, refused or the task was not applicable as follows:
- for residents #015, #017 and #018, on 10 out of 12 night shifts; three out of 12 day shifts; six out of 11 evening shifts;
- for residents #021, #023 and #024, on 10 out of 12 night shifts; three out of 12 day shifts; five out of 11 evening shifts;
- for resident #022, on 10 out of 12 night shifts; four out of 12 day shifts; eight out of 11 evening shifts;

- for resident #019, on 10 out of 12 night shifts; two out of 12 day shifts; six out of 11 evening shifts;
- for resident #020, on 10 out of 12 night shifts; four out of 12 day shifts; six out of 11 evening shifts;
- for resident #003, on 10 out of 12 night shifts; three out of 12 day shifts; six out of 11 evening shifts; and
- for resident #025, on 10 out of 12 night shifts; five out of 12 day shifts; seven out of 11 evening shifts.

During this review, the Inspector also noted that the provision of a morning beverage and an afternoon beverage and/or snack were not captured as separate nourishment passes. Instead, there was one cell for staff to document the nourishment provided on the day shift. The entries were documented as "F" for full, "R" for refused or "8" for activity did not occur. No entries contained a volume of fluid consumed. On April 15 and 16, nine out of the 11 residents had no documented beverage or snack intake for the entire weekend.

A review of the same unit's PSW Assignment binder #4, from April 15 to the day shift on April 26, 2018, with focus on beverages and snacks, identified similar missing documentation and consumption coding on all three shifts for residents #026, #027, #028, #029, #030, #031, #032, #033, #034 and #035. In addition, the Inspector noted that all of these residents did not have any documented beverage or snack nourishment passes on April 22, 2018.

During an interview with PSW #105, they stated that, since April 15, 2018, there were "loads of times the snack cart [was] not done". The PSW identified that the staff make a decision between providing beverages and snacks to residents, and toileting residents, keeping them dry and helping them to the bathroom.

During an interview with PSW #131, they stated that the home had been working with staff shortages of two, three or four PSWs out of eight PSWs on day shifts and out of six PSWs on evenings. The PSW identified that the home worked short on a date in April 2018, when five out of eight PSWs worked, and that all of the documentation may not have been completed that shift. The PSW explained that they had been responsible for providing care to approximately 30 residents (taking into account the vacant beds in the home) for multiple consecutive dates and had completed the documentation for one PSW Assignment binder that had been their original assignment. The PSW stated the Activation department completed the morning beverage pass, Activation staff did not sign for beverages and snacks in the PSW Flow Sheets, but they "usually tell us if someone

hasn't taken a snack". The PSW acknowledged that there were multiple cells of missing documentation from beverage and snack passes for various shifts on two dates in April 2018, and for all shifts for some residents. The PSW also identified that PSW Assignment #3 binder had not had charting completed for six days.

During an interview with PSW #132, they stated, since April 15, 2018, the home had worked short. The PSW identified that most day shifts the unit was short one, two or three PSWs out of eight, and the PSW had worked multiple evening shifts with three out of six PSW staff present. They identified that they had worked on a date in April 2018, with five out of eight staff present. The PSW commented that, when working short and attempting to provide the required resident care, the staff "won't be able to do other things like sign the book…We just don't have time for paperwork. We can usually do our own but not the paperwork for the other assignments we picked up, we can't be responsible to complete three assignment binders."

During an interview with PSW #124, they stated that, on a date in April 2018, a particular unit had four staff over several hours and two staff for another portion of the shift, to provide care for approximately 90 residents on the unit when full. [71 residents resided on the unit on this date in April 2018.] The PSW identified that the beverage and snack pass had been completed by Dietary staff that evening but that the PSW Assignment binder #4 had not been signed to reflect that.

During an interview with RPN #129, they stated that they had worked in the home on a date in April 2018, when the home was working short staffed. The RPN identified that the Activation and Dietary departments assisted with the beverage and snack carts, that some staff from the other departments did not know the names of some of the residents but pointed them out and said "these two didn't take anything". The RPN reviewed a unit's PSW Assignment binders #1 and #3 and identified that the provision of beverages and snacks was not documented on that date in April 2018.

During an interview with the ADOC, they stated that they completed audits on the provision of beverages and snacks by physically viewing the carts to see if they had been distributed and, with respect to the evening beverage and snack pass, by asking the staff and/or checking the PSW Flow Sheets to see if they were signed for. During a second interview, the ADOC stated that they did not audit the documentation of the provision of nourishments to residents, only that the nourishment pass was completed and "Once it is done, the HCAs are to ensure they document. I ensure the carts are served." The ADOC stated they had verbally asked the RNs if snacks were completed over the past two

weekends "That's what I do to ensure they were served". The ADOC acknowledged that the beverage and snack passes had been completed but that staff had not documented the provision of the beverages and snacks as required. The ADOC also acknowledged that the current PSW Flow Sheet used by the home did not contain individual areas to document both the morning and afternoon beverage and snack passes. Upon review of the PSW Flow Sheet, the ADOC stated they could not determine if the values entered applied to both, or either of the passes, and the sheet was being revised. With respect to the use of "F" to reflect "full" as a documented entry, the ADOC stated that "full" did not reflect a quantity, it "means they have had enough". The ADOC explained that the sheet required revision so that staff could record the amount of fluid consumed so that the total fluid intake of residents within a 24 hour period to could be determined. [s. 6. (9) 1.]

9. A CIS report was submitted to the Director for an incident of alleged neglect that occurred in the winter of 2018. The report indicated that resident #008 waited for a prolonged period of time for staff to assist them to attend a meal, which they had not been provided with. Long-term actions to correct the situation and prevent recurrence listed by the home included "Since the incident, staff are to check after each meal to ensure that all residents attend or document refusal with an offer of a meal brought to them. To date we have not had any residents miss their meals since the implementation of this procedure."

Inspector #625 reviewed resident #008's care plan titled Nutritional Status, last updated in the spring of 2018, which identified staff were to provide the resident with assistance, as required, with meals.

A review of the resident's GoldCare electronic progress notes identified that, since the incident, the resident had refused meals on multiple occasions.

A review of the Nutrition Intake Chart, which listed the percent of intake and assistance provided to the resident at each meal, identified:
- In one month in 2018, 65 per cent of breakfast meals were not signed for; 67 per cent of lunch meals were not signed for; and 50 per cent of supper meals were not signed for.
- In another month in 2018, 52 per cent of breakfast meals were not signed for; 42 per cent of lunch meals were not signed for; and 39 per cent of supper meals were not signed for.
- In a third month in 2018, 30 per cent of breakfast meals were not signed for; 30 per cent of lunch meals were not signed for; and 57 per cent of supper meals were not signed for.
The Nutritional Intake Chart did not contain documentation related to resident #008's

refusal of breakfast on a date in one month; refusal of lunch on multiple dates in two months; or refusal of supper on a date in the third month. However, the chart did include documentation entered on a date in one month in 2018, for supper which identified the resident consumed their meal, and had not refused it as documented in the progress notes.

Inspector #625 reviewed resident #008's PSW Flow Sheets for a month in 2018, which listed the level of assistance provided to the resident during each meal, as well as the beverages and snacks provided to each resident during each shift, including resident refusals. The Inspector identified that:
- 61 per cent of breakfast entries were not documented;
- 30 per cent of lunch entries were not documented;
- 83 per cent of supper entries were not documented;
- 100 per cent of night food and/or fluid nourishment passes were not documented;
- 57 per cent of day food and/or fluid nourishment passes were not documented; and
- 91 per cent of evening food and/or fluid nourishment passes were not documented.
The Inspector also noted that the documentation of the level of assistance the resident required with eating lunch on multiple dates in that month, did not coincide with the documentation in the progress notes that the resident had refused lunch on those dates.

During an interview with RPN #117, they stated that PSW staff were responsible to complete the Nutritional Intake Chart for the resident and that staff were required to document any refusals.

During an interview with RPN #118, they stated that resident #008's nutritional intake should be documented on the PSW Flow Sheets each shift, and all areas should be completed as there is an option to indicate “Activity Did Not Occur”. The RPN also identified that the Nutritional Intake Chart would also include documentation of the resident’s intake. The RPN acknowledged that, on resident #008’s PSW Flow Sheets for a month in 2018, 57 per cent of each meal did not contain documentation identifying the level of assistance provided to the resident, including if the activity did not occur. The RPN also identified that 83 per cent of the shifts, had no documented nourishment food or fluid intake (beverages or snacks). The RPN indicated that each meal should have documentation but that it may not have been completed as providing care to the resident may not have been assigned to a specific staff member, resulting in no one completing the required documentation. The RPN also reviewed the Nutritional Intake Chart for resident #008 for the month in 2018, and identified multiple dates where full or partial documentation had not been entered. The RPN indicated that each part of the Nutritional

Intake Chart, should have had something documented, even if the resident had refused the meal or was not in the home.

During an interview with RPN #119 they stated that staff were required to document resident #008's meal intake on a Nutrition Intake Chart and beverage and snack passes on PSW Flow Sheets. The RPN stated that resident #008 should have something documented for each meal and nourishment pass, even if they were absent from the home, were sick or refused. The RPN acknowledged that the resident's PSW Flow Sheets and Nutritional Intake Chart for a month in 2018, had blanks where documentation was required with respect to the resident's intake. The RPN confirmed that a GoldCare progress note identified resident #008 had refused lunch on a date during that month in 2018, but that the Nutrition Intake Chart did not reflect that the meal was refused, and should have. The RPN acknowledged, with respect to documentation of the resident's meals and beverage and snack passes, that the care provided, as per resident #008's plan of care, had not been documented.

During an interview with Inspector #625, the home's Administrator indicated that staff were required to document resident #008's meal intake and assistance provided on the Nutritional Intake Chart, and their beverage and snack pass intake and assistance provided on the PSW Flow Sheet. The Administrator stated that staff were required to document refusals, if the resident was absent, or if the activity did not occur on the sheets, but that the sheets did not have consistent documentation of the meals and nourishment passes as some were incomplete. The Administrator acknowledged that the resident's refusals of lunch on multiple dates in a month in 2018, as documented in GoldCare progress notes, had not been documented on the Nutritional Intake Chart. They also acknowledged that the long-term corrective action listed in the CIS report, specifically documenting the resident's refusal of meals, was not being completed, and the care provided to resident #008, as per their plan of care with respect to meals and beverage and snack passes, had not been documented. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

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 that ensures that:
- there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; and
- the provision of care set out in the plan of care is documented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation.

The licensee has failed to comply with CO #001 from inspection #2018_509617_0004 served on March 15, 2018, with a compliance date of April 15, 2018.

The licensee was ordered to:
A) Review, revise and implement their staffing plan to ensure that assessed resident care and safety needs are met;
B) Recruit and retain staff to fill all staffing vacancies and reduce the amount of nursing shortage hours;
C) Develop, implement, and maintain records for an auditing process to ensure that when working short staffed, all resident care that is missed is followed up with;
D) Improve the communication between staff and management to determine gaps in providing resident care, safety issues, and actions taken by providing and recording monthly staff meetings.

The licensee completed part D in CO #001.

The licensee failed to completed parts A, B and C regarding the staffing plan, staffing vacancies and auditing processes.

(A) With respect to part A, the licensee was ordered to review, revise and implement their staffing plan to ensure that assessed resident care and safety needs were met.

Inspector #625 reviewed documents provided by the home's Administrator and DOC related to part A of the order including a Staffing Evaluation Plan that identified the home had the following staff complement:

(a) on the day shift one unit had three registered nursing staff and eight PSWs; another unit had three registered nursing staff and six PSWs; and a third unit had two registered nursing staff, two PSWs and two additional staff providing ordered enhanced staffing.

(b) on the evening shift one unit had two registered nursing staff and six PSWs; another unit had three registered staff and four PSWs; and a third unit had one registered staff, two PSWs and two additional staff providing ordered enhanced staffing.

(c) on the night shift one unit had one registered nursing staff and two PSWs; another unit had one registered nursing staff and two PSWs and a third unit had no specifically

designated registered nursing staff, two PSWs and two additional staff providing ordered enhanced staffing.
The plan also identified that the back-up plan to address staff shortages was reviewed on February 29, 2018, and was used continuously due to staff shortages.

The Inspector also reviewed a document titled Nursing – Staffing Contingency Plan - Rainycrest, which had been reviewed by the home and updated to address the order. Both the current and previous versions identified that, if the home was working with two or more PSWs short, staff were to "Prioritize baths, down grade bath to bed bath. If a bath is missed, staff on next shift to be made aware so they can pick it up."

The Inspector reviewed a document titled Rainycrest – Recommended change in staff ratio compared LTC average in similar # of beds, dated April 20, 2018, that compared the home's staffing levels to average staffing levels in long term care. The document identified, when fully staffed and with no resident vacancies:
(a) one unit, comprised of 84 resident beds, had eight PSWs to work day shift, compared to an average of eight to ten PSWs; six PSWs to work evening shift, compared to an average of seven to eight PSWs; and two PSWs to work night shift, compared to an average of 2.5 to three PSWs;
(b) another unit, comprised of 59 resident beds, had six PSWs to work day shift, compared to an average of six to seven PSWs; four PSWs to work evening shift, compared to an average of five to six PSWs; and two PSWs to work night shift, compared to an average of two PSWs; and
(c) a third unit, comprised of 21 resident beds, had two PSWs to work day shift, compared to an average of 2.5 to three PSWs; two PSWs to work evening shift, compared to an average of 2.5 to three PSWs, and two PSWs to work night shift compared to an average of one PSW. The document did not include the ordered enhanced staffing present on the third unit during each shift.
The document identified that consideration was being taken to increase staffing levels on the two of the units.

Inspector #625 also reviewed meeting minutes from an ONA Labour Management Meeting held on April 24, 2018, which identified the revised contingency plan had been implemented and placed in the scheduling binder; ONA representative #133 indicated that the contingency plan was not working; and RN #134 identified there was no email advising that the amended contingency plan was placed in the binder.

During an interview with Receptionist #135, they stated they completed the scheduling of

vacant shifts, with a focus on the day-to-day and short notice coverage of shifts. When asked if they were familiar with the revised Nursing – Staffing Contingency Plan – Rainycrest document, the Receptionist stated that they had not seen the plan until approached by the Inspector four days after the order was due, and would not have known that the plan had changed as they were not told that it had changed or of the specific changes made.

During an interview with Administrative Assistant #136, they stated that they did day-to-day staffing when assisting Receptionist #135, or if the Receptionist was not present and they were providing coverage. The Administrative Assistant stated they were not familiar with the staffing contingency plan in its entirety.

During an interview with RN #114, they stated that they were aware of the existence of the home's staffing contingency plan document and that it was located in the scheduling binder, but that that they were not aware if the plan had been updated and would follow the instructions provided to them by Receptionist #135 when redistributing staff during staffing shortages.

During an interview with RN #137, they stated that they had not been notified that the staffing contingency plan had been changed.

During an interview with RN #113, they stated that, at times, they were responsible to call in staff. The RN stated that they were familiar with the staff contingency plan and noted "one side can be short on even days, the other side the opposite". [This direction was listed on the former plan for shortage of one PSW but had been removed from the revised plan.]

During an interview with Inspector #625, the Administrator discussed the review of the home's staffing plan and identified that consideration to increase the staffing ratios during the evening and night shifts on two of the units had not been implemented. The Administrator acknowledged that the home had reviewed their staffing plan and identified areas where staffing levels could be improved, but that the home had not revised or implemented the changes to the staffing plan as they continued to work on recruiting staff.

The license failed to complete part (A) of the order as the home had not revised or implemented changes to the staffing plan to ensure that assessed resident care and safety needs were met.

(B) With respect to part B, the licensee was ordered to recruit and retain staff to fill all staffing vacancies and reduce the amount of nursing shortage hours.

(i) Staffing Vacancies
Inspector #625 reviewed documents provided by Administrative Assistant #136 (who completed long term and advanced scheduling replacement) and identified:
- the full staffing complement in the home consisted of:
    (a) RNs – two full time Unit Coordinators, four full time floats and four part time staff;
    (b) RPNs – 12 full time and seven part time staff; and
    (c) PSWs – 39 full time and 11 part time staff.
- On February 9, 2018, the last day of inspection #2018_509617_0004, the home had two part time RN vacancies. On March 15, 2018, the day the home was served CO #001 from inspection #2018_509617_0004, the home had one full time and two part time RN vacancies. On April 15, 2018, the day CO #001 was due, the home had one full time and two part time RN vacancies. The home had not hired any new RNs from February 9 to April 15, 2018.
- On February 9, 2018, the home had one full time and two part time RPN vacancies. On March 15, 2018, the home had two part time RPN vacancies. On April 15, 2018, the home had two part time RPN vacancies. The home had hired one casual RPN in February, one full time RPN in February and one agency RPN in March 2018.
- On February 9, 2018, the home had eight full time PSW vacancies. On March 15, 2018, the home had six full time PSW vacancies and one part time PSW vacancy. On April 15, 2018, the home had eight full time and four part time PSW vacancies. The home had hired one full time PSW in April (prior to the compliance date), two casual PSWs in April (after the compliance date) and one full time PSW in April 2018 (after the compliance date).

The Inspector reviewed the home's staffing schedules which were consistent with the documents provided by Administrative Assistant #136, which indicated that, as of April 15, 2018, the home had one full time and two part time RN vacancies; two part time RPN vacancies; and eight full time and four part time PSW vacancies.

During an interview with Administrative Assistant #136, they acknowledged the vacancies as identified on the staff schedule.

During an interview with the DOC, they acknowledged the home had vacant positions including one full time and one part time RN, two part time RPNs, and multiple full and

part time PSWs.

During an interview with the home's Administrator, they provided a document to the Inspector they stated originated from their Human Resources Department, which identified staffing vacancies as two part time RNs, two part time RPNs, three full time PSWs and four part time PSWs. The Administrator was not able to explain why the number of staffing vacancies on the document supplied by the Human Resources Department differed from the information located on the home's staff schedules and the information provided by the Administrative Assistant. The Administrator stated that they "haven't laid anyone off" but acknowledged the home continued to experience staffing vacancies in the RN, RPN and PSW classifications and that, with respect to part B of CO #001, all components had not been completed, as the home still needed to do some other things and implement some things.

(ii) Nursing Shortage Hours
Inspector #625 reviewed the document Nursing Current Staffing maintained and provided by Administrative Assistant #136. The document identified the daily staffing complement in place in the home as 45 RN hours per day on weekdays and 37.5 RN hours per day on weekends; 82.75 RPN hours per day; and 248.5 PSW hours per day.

Inspector #625 reviewed a spreadsheet titled Nursing Shortage Hours, compiled by Receptionist #135, which identified the number of staffing hours short per day for registered staff and PSWs, from January 1 to April 25, 2018. The document identified the home experienced the following staffing shortages:
- in January 2018 the home was short 67.25 registered nursing staff hours and 640.5 PSW hours (with an average of 20.7 PSW hours short per day and a daily maximum of 55.5 PSW hours short). The total staff hours short was 707.75 hours, for a daily average of 22.8 hours.
- in February 2018 the home was short 65.5 registered nursing staff hours and 593 PSW hours (with an average of 21.2 PSW hours short per day and a daily maximum of 58 PSW hours short). The total staff hours short was 658.5 hours, for a daily average of 23.5 hours.
- in March 2018 the home was short 44 registered nursing staff hours and 802 PSW hours (with an average of 25.8 PSW hours short per day and a daily maximum number of 58 PSW hours short). The total staff hours short was 846 hours, for a daily average of 27.3 hours.
- from April 1 to 14, 2018, the home was short 38.25 registered nursing staff hours and 465.5 PSW hours (with an average of 33.25 PSW hours short per day and a daily

maximum number of 61 PSW hours short). The total staff hours short was 503.75 hours, for a daily average of 36 hours.

The Inspector reviewed the spreadsheet with a focus on the shortages experienced after the compliance date of April 15, 2018, and determined that, from April 15 to 25, 2018, the home was short 22.75 registered nursing staff hours and 308 PSW hours (with an average of 28 PSW hours short per day and a daily maximum number of 60 PSW hours short). The total staff hours short was 330.75 hours, for a daily average of 30 hours. The Inspector noted that the average daily number of nursing shortage hours had not been reduced from the period of time of inspection #2018_509617_0004 in February 2018, to the period of time CO #001 was served to the home in March 2018, to the most recent data analyzed from April 15 to 25, 2018.

Inspector reviewed the Riverside Health Care Facilities – Rainycrest Staffing Document used by the home's management team to document and track daily forecasted and actual staff absences. The Inspector noted that, on April 16, the document identified the home had been short 2.5 PSW shifts, or 18.75 hours, and that dietary staff assisted with evening snack pass. When the Inspector compared the document to the Nursing Shortage Hours maintained by Receptionist #135, it was identified that the values tracked differed as the document listed that the home had been short 33 PSW hours on April 16, 2018. The Inspector noted that the hours listed on other dates were also inconsistent between the two documents.

During an interview with the DOC, they stated that the home's management and administration maintained the document titled Riverside Health Care Facilities – Rainycrest Staffing Document. The DOC indicated the number of PSW staff shortage hours reflected on the document on April 15, 2018, 5.5 PSWs, or 41.25 hours, differed from that tracked by Receptionist #135 on the Nursing Shortage Hours spreadsheet, which identified the home had been short 44 PSW hours that date. The DOC stated that the Riverside Health Care Facilities – Rainycrest Staffing Document had reflected the use of supplemental staff [non-PSW staff from other departments who could assist with activities on the unit other than personal care].

During an interview with the Administrator, they stated that, with respect to the nursing shortage hours experienced by the home, the home had been in a gastric outbreak from February 13 to March 5, 2018, and were currently experiencing a respiratory outbreak that began on April 5, 2018. The Administrator stated the home continued to experience nursing shortage hours, including those due to sick calls, and that recruitment efforts

were being made.

The licensee failed to complete part (B) of the order as the home failed to recruit and retain staff to fill all staffing vacancies and reduce the amount of nursing shortage hours.

(C) With respect to part C, the licensee was ordered to develop, implement, and maintain records for an auditing process to ensure that when working short staffed, all resident care that was missed was followed up with.

(i) The home had failed to develop, implement and maintain records for auditing of skin and wound care treatments to ensure that when working short staffed, all resident care that was missed, with respect to skin and wound care treatments, was followed up with.

A review of an ONA/Long-Term Care Professional Responsibility (PRW) Report Form by Inspector #625 identified that, due to staffing shortages on a date in April 2018, all treatments had not been completed on two units.

The Treatment Records – Long Term Care did not identify that resident #012 had an intervention for altered skin integrity completed, at a specified frequency, on the date identified on the ONA form; or that resident #013 had skin and wound care treatments completed on the date identified on the ONA form, as well as on two additional dates.

A review of the Nursing Shortage Hours spreadsheet for the date identified on the ONA form, identified that the home worked with a shortage of 11.25 registered nursing staff hours [out of 37.5 hours] and 60 PSW hours [out of 248.5 hours] that day.

Inspector #625 reviewed a Rainycrest Wound Auditing Sheet for a particular unit for one week in April 2018, which had been completed five days after the end of that week, by RN #130, the home's Skin and Wound Care Lead. The audit did not identify the missed treatments on the two additional dates in April when resident #013 had missed the interventions, and did not include any treatments missed during the five days between the end of the audited dates and the date of the audit (specifically the missed interventions for residents #012 and #013 that occurred on the day following the last date included in the weekly audit).

During an interview with Inspector #625, RN #130 acknowledged that resident #013's skin and wound care intervention to be completed at a specific frequency had not occurred on three dates in April 2018, and resident #012's skin and wound care

intervention had not been completed on a date in April 2018. The RN acknowledged that the skin and wound care interventions should have been completed but had not been audited, identified and/or addressed as of a date in April 2018.

See Written Notification (WN) #1, finding #4, for details.

(ii) The home had failed to develop, implement and maintain records for auditing of the provision of beverages and snacks to ensure that when working short staffed, all resident care that was missed, with respect to the provision of beverages and snacks, was followed up with.

During interviews with PSW #105, they stated that, since April 15, 2018, the snack cart had not been distributed to residents on numerous occasions as there were not enough staff to ensure the distribution of the snacks as well as ensure the residents were toileted, kept dry and helped to the bathroom.

During interviews with PSWs #131, #132 and #124 and RPN #129, they stated that they had been working with staff shortages on specific dates since April 15, 2018, and that all components of resident care could not be completed when they worked short. PSWs #124 and #131 and RPN #129 identified that the Activation and/or Dietary departments had completed nourishment passes on the identified dates the PSW staff worked short. PSWs #124, #131 and RPN #129 acknowledged that the other departments did not and/or had not signed PSW Flow Sheets to reflect the distribution of the snack passes they had provided. PSW #131 stated that Activation staff "usually tell us if someone hasn't taken a snack" and RPN #129 stated staff from the Activation and Dietary departments did not know the names of some of the residents but would point them out and say "these two didn't take anything".

See WN # 1, finding #8, for details.

(iii) Although the home had developed, implemented and maintained records for auditing of bathing of residents, the process in place failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation with respect to bathing. The home failed to ensure that, when the home worked with less than the full complement of staff, residents were bathed twice a week by the method of their choice, where "bathing" included tub baths, showers, and full body sponge baths.

Inspector #625 reviewed a document titled Nursing – Staffing Contingency Plan - Rainycrest, which identified that, if the home was working with two or more PSWs short, staff were to "Prioritize baths, down grade bath to bed bath. If a bath is missed, staff on next shift to be made aware so they can pick it up."

During an interview with PSW #138, they stated that, on a date in April 2018, one unit had been short three PSWs on days shift [out of 8] and only had two PSWs instead of six on evenings. The PSW stated the home's management told the staff that baths had to be completed, even bed baths. The PSW indicated that the staff just washed residents' armpits and groin but that was not the same as a bath to the PSW. The PSW noted that the staff document this type of limited bath provided as a bed bath and that staff were not able to make up missed baths on the following shifts when the following shift was also working short.

During an interview with PSW #105, they stated that resident baths were not getting completed all the time as "there isn't a day when we aren't short staffed. There is no way possible that, when we're working short, we can pick up baths from the previous shift. When we do pick them up, people are getting baths back-to-back, two days in a row and then not bathed for another week". The PSW stated that some residents had been given bed baths and "they weren't happy" about it. The PSW identified that resident #036 did not receive a bath on a date in April 2018, and had been rescheduled to the following day, but did not receive that bath either. The PSW identified that the resident had a particular type of bath on two dates in April, and a different type of bath on a third date in April, although their care plan identified they were to have a different type of bath than that provided on the third date. The PSW also identified that resident #037 did not have a bath on a date in April as there were three PSWs on day shift instead of 5.5. The PSW identified that the resident's bath had not been made up the following day and their next scheduled bath was due three days after their missed bath.

Inspector #625 reviewed the Bath Schedule Days and identified that resident #036 was to bathe at a specified frequency, resident #036's current care plan that identified they were to have a particular type of bath and required staff assistance, their Head to Toe that had skin assessments [to be completed with each bath] documented on two dates in April, the PSW Flow Sheets that listed the resident had a specific type of bath on two dates in April and a different type of bath, which differed from that listed in their care plan, on a third date in April, and Gold Care progress notes that had no documentation related to the resident's bathing.

Inspector reviewed the Bath Schedule Days and identified that resident #037 was to bathe at a specified frequency, resident #037's current care plan that identified the resident's preferred method of bathing and that the resident required staff assistance, their Head to Toe which was last completed on a date in April, the PSW Flow Sheets that listed the resident had a specific type of bath five days earlier, and Gold Care progress notes that had no documentation related to the resident's missed bath.

During an interview with PSW #128, they stated residents who required the use of a particular type of transfer equipment were being given bed baths instead of tub baths if the unit worked short.

During an interview with RPN #129, they stated that working short resulted in residents not being provided with time to do activities of daily living independently, as the staff completed the activities for the residents so that items such as bathing and washing could occur. The RPN stated "We don't prompt or cue, just do it so that they do have care". The RPN identified that many baths were being missed and were not always made up as the next shift, which was expected to make up the missed baths, was working short too. The RPN identified that resident #038 had their last bath on a date in April and had not had a bath since then, seven days later, as per the documentation on the PSW Flow Sheets and Head to Toe Assessment. The RPN identified that the resident was supposed to have a bath on a date in April, and it was written to make up to bath on the following date, but that it was not checked off as completed.

Inspector #625 reviewed the Bath Schedule Days and identified that resident #038 was to bathe at a specific frequency, resident #038's current care plan that identified they were to bathe in a particular manner and required staff assistance, their Head To Toe that had a skin assessment documented last on a date in April, the PSW Flow Sheets that listed the resident bathed in a manner other than that listed in their care plan on a date in April, and Gold Care progress notes that had no documentation related to the resident's missed bathing.

During an interview with PSW #124, they stated that the auditing and follow-up of bathing residents has been incorrect, as one resident noted for a make-up bath in the unit calendar was bathed twice.

During an interview with PSW #139, they acknowledged that some residents were provided with baths on two consecutive days in an effort to make up a missed bath.

During an interview with the ADOC, who conducted the bathing audits, they stated that resident #038 did not have the bath missed on a date in April 2018, made up. The ADOC indicated that they believed the resident had a sponge bath but did not know why a sponge bath was provided to the resident. The ADOC stated that resident #036 did not receive a specific type of bath on a date in April 2018, and had not had that type of bath made up. The ADOC was not able to identify why the resident was provided with a particular type of bath on April 21st, and stated that residents’ preferences for bathing should be upheld. The ADOC also acknowledged that resident #037 had not been provided with their bath on a date in April 2018, and that, if the staff were able to make up the missed bath on that date, the resident would have not had a bath for five days, and would then have two baths in three days. The ADOC acknowledged that they were aware of some residents receiving make-up baths two days apart from their next scheduled bath. The ADOC acknowledged that it was not a best practice to provide baths at the altered frequency discussed and stated “that’s when we could ask them to give a bed or sponge bath in the meantime”.

The licensee failed to complete part (C) of the order as the home failed to develop, implement, and maintain records for an auditing process to ensure that when working short staffed, all resident care that was missed was followed up with, with respect to skin and wound care, the provision of beverages and snacks, and the provision of bathing as per residents' preferences and plans of care.

(D) Non-Compliance Pursuant to Ontario Regulation 79/10, s. 31 (3)

(i) The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents’ assessed care and safety needs and that met the requirements set out in the Act and this Regulation with respect the safe transferring and positioning devices or techniques when assisting residents with the use of mechanical lifts.

Inspector #617 reviewed the home's policy titled, "Minimal Lift Procedures-#ORG-III-NGE-15.01", last updated on January 30, 2018, which indicated that the use of a sit-to-stand mechanical lift required two persons to operate in which the second caregiver was given specific instruction on lowering the resident in the lift.

On a date in April 2018, Inspector #617 observed resident #002 being transferred by a PSW using a mechanical lift in an unsafe manner.

PSW #146 reported to Inspector #617 that they had performed the lift in an unsafe manner because the unit was short staffed.

Inspector #617 conducted an interview with Receptionist #135, in which both the Inspector and the receptionist reviewed the date of the incident nursing schedule. The Receptionist confirmed to the Inspector that the unit where resident #002 resided, was working one PSW short for the day shift. The unit was required to be staffed with five PSWs and there had been four PSWs providing care to the residents on the unit. [51 residents resided on the unit on the date of the incident].

During interviews with both RPN #129 and PSW #147, they both confirmed to Inspector #617 that resident #002 required the use of a mechanical lift which was to be operated in a specific manner to maintain safety.

In a separate interview with PSW #147, they reported to the Inspector that they had used the mechanical lift in an unsafe manner on several occasions for some of the residents due to the unit working short staffed, in an effort to maintain resident continence.

During an interview with Inspector #625, PSW #105 stated that, since April 15, 2018, when the home worked short staffed they had transferred residents using a mechanical lift in an unsafe manner. The PSW stated that they didn't want to do it but sometimes it couldn't be helped when there were only three staff on the floor and someone may have gone for a break. They further stated that the transfers had to be completed in that way if the residents had to go to the bathroom as they "can't just let them sit there and wet themselves".

During an interview with Inspector #625, PSW #131 stated that, since April 15, 2018, they have worked with staff shortages of two, three or four PSWs out of eight PSWs on a day shift and out of six PSWs on an evening shift. The PSW identified that they had been responsible to provide care to approximately 30 resident on multiple consecutive dates after April 15. The PSW acknowledged that there were many mornings the staff transferred residents to toilet and to get up using a mechanical lift in an unsafe manner. The PSW stated that they knew it was not safe but in the long run they were trying to prevent a fall as residents had tried to crawl out of bed. The PSW further explained that one day three falls occurred in one hour as the PSW had been attempting to assist all of the residents but could not do so. The PSW stated that they have waited for 15 minutes for assistance from other staff with transfers, and then completed an unsafe transfer as the staff felt they were doing what was best for the resident.

During an interview with Inspector #625, PSW #132 stated that they used mechanical lifts in an unsafe manner when they worked short, and that if they knew the resident and their cognition, they would do it. The PSW identified that they had worked short every day since April 15, 2018, and specifically identified they worked multiple times with three out of six PSW staff on evening shifts, and had worked with one, two or three PSW staff short, out of eight PSWs, on day shifts.

See WN #4, finding #1, for details.

(ii) The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation, with respect to toileting residents.

During an interview with Inspector #625, PSW #124 stated that, since April 15, 2018, they had worked with less than the full staffing complement "most of the time". The PSW specifically identified that, on a date in April 2018, they had worked with a staff complement of four PSWs for six hours and two PSWs for two hours, on a unit where approximately 90 residents resided when fully occupied. The PSW stated that it was frustrating to them to be told to focus on getting baths completed, which resulted in residents who needed to be toileted not being toileted or having to wait to be toileted. The PSW identified that residents who had been up before supper, sitting in the lounge, would have to wait until the staff put them to bed to be toileted. The PSW acknowledged that residents who required toileting before supper were not toileted if the home was short staffed.

During an interview with PSW #139, they also stated that residents who required toileting before supper were only toileted if they could ring for staff assistance and could wait for staff, but that the other residents had to wait until after supper to be toileted.

(iii) The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation, with respect to bed time and sleep routines.

During an interview with PSW #124, they stated that, on a date in April 2018, when they worked short on a unit in the home, two residents were still up at 2230 hours because the staff didn't have the time to put the residents to bed. The PSW stated that the residents

had to wait for the night shift staff to arrive to assist them to bed.

Inspector #625 reviewed the Nursing Shortage Hours spreadsheet and identified that the home had worked with a shortage of PSW hours each day, out of a total of 248.5 daily PSW hours, since April 15, 2018 of:
- 44 PSW hours, or 18 per cent of the PSW hours, on April 15;
- 33 PSW hours, or 13 per cent of the PSW hours, on April 16;
- 29.5 PSW hours, or 12 per cent of the PSW hours, on April 17;
- 20 PSW hours, or 8 per cent of the PSW hours, on April 18;
- 22 PSW hours, or 9 per cent of the PSW hours, on April 19;
- 7 PSW hours, or 3 per cent of the PSW hours, on April 20;
- 26.5 PSW hours, or 11 per cent of the PSW hours, on April 21;
- 60 PSW hours, or 24 per cent of the PSW hours, on April 22;
- 40.5 PSW hours, or 16 per cent of the PSW hours, on April 23;
- 27 PSW hours, or 11 per cent of the PSW hours, on April 24; and
- 28 PSW hours, or 11 percent of the PSW hours, on April 25, 2018.

The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation, with respect to safe transferring techniques, the provision of toileting assistance and bed time and sleep routines. [s. 31. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the training and retraining for staff in infection prevention and control (IPAC) required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act was completed.

On February 20, 2018, CO #002 from inspection #2018_509617_0004 was issued pursuant to Ontario Regulation 79/10, s. 219. (4) (a).

The Licensee was ordered to:
1) Provide annual training to all registered and direct care staff members regarding the home's written policy and the process for hand hygiene, modes of infection and transmission, and use of personal protective equipment (PPE) in accordance with O. Reg. 79/10, s. 219 (4).
2) Keep a record of the education content, names of all staff trained, and dates when the training is completed.
3) Develop, implement, and maintain records for an auditing process to ensure that staff are performing proper hand hygiene and use of PPE; in addition, where the auditing process identifies performance issues, action is taken.

The compliance due date was February 28, 2018.

The licensee completed steps two and three of the order.

The licensee failed to complete step one of the order.

Inspector #642 reviewed the following documents:
- Surge Learning System, Public Health Ontario: Just Clean your Hands-Professional

Staff, dated January 1, 2017, to April 24, 2018. The Inspector identified that 13 out of 145 direct care staff, or nine per cent of the direct care staff, had not completed the education required;
- Surge Learning System, Donning and Doffing of PPE with N95, dated January 1, 2017, to April 24, 2018. The Inspector identified that 10 out of 116 direct care staff, or nine per cent of the direct care staff, had not completed the education required; and
- Surge Learning System, Infection Prevention and Control Refresher, dated January 1, 2017, to April 24, 2018. The Inspector identified that 11 out of 145 direct care staff, or eight per cent of the direct care staff, had not completed the education required.

During interviews with PSWs #123, #125, and # 126, they stated they had not completed required education, which included the process for hand hygiene, modes of infection and transmission, and the use of personal protective equipment (PPE) by the due date.

Inspector #642 interviewed the Infection Control Practitioner who stated that the infection control education was only provided on Surge Learning, and not all the direct care staff had completed the education by April 15, 2018.

Inspector interviewed the DOC and the Administrator, who both stated that the IPAC education should have been completed by all direct care staff by the compliance date in the order, but that not all staff had completed the education as required, and that the completion of the required education was still outstanding for multiple staff.

The licensee failed to complete part one of CO #002, which required the home to train all direct care staff regarding the home's written policy and the process for hand hygiene, modes of infection and transmission, and the use of PPE. This portion of the order could not be complied. [s. 219. (4)]

Additional Required Actions:

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

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

Findings/Faits saillants :

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

A complaint was submitted to the Director regarding the proper toileting of resident #002, when required.

On a date in April 2018, Inspector #617 observed PSW #146 transfer resident #002 using a mechanical lift in an unsafe manner. Resident #002's family member was in the room visiting at the time.

In an interview with PSW #146, they reported to the Inspector, that they had just assisted resident #002 using the mechanical lift, and explained that they had used the lift in an unsafe manner.

During an interview with resident #002's family member, they confirmed to the Inspector that they were in the room when PSW #146, used the mechanical lift in an unsafe manner. The family member explained that they had usually seen the lift used in a different manner than what they observed that day.

A review of resident #002's care plan dated the winter of 2018, indicated that the resident required staff assistance with transferring in a particular manner, using a mechanical lift. A review of the PSW Flow Sheet documentation of the care provided to the resident indicated that a mechanical lift was used in a particular manner to transfer the resident on certain shifts in April 2018. Documentation was missing for date in April when Inspector #617 observed the resident transferred in an unsafe manner.

In interviews with both RPN #129 and PSW #147, they both confirmed to the Inspector that resident #002 required the use of a mechanical lift to transfer, to be operated in a particular manner to maintain safety.

In a separate interview with PSW #147, they reported to the Inspector that they had used the mechanical lift, in an unsafe manner, on several occasions for some of the residents due to the unit working short staffed in an effort to maintain resident continence.

A review of the home's policy titled, "Minimal Lift Procedures-#ORG-III-NGE-15.01", last updated on January 30, 2018, indicated that the use of a sit-to-stand mechanical lift

required two persons to operate in which the second caregiver was given specific instruction on lowering the resident in the lift.

In an interview with the DOC they confirmed that PSW #146 improperly transferred resident #002 by performing the lift in an unsafe manner and the lift should have been operated in a different manner for the resident's safety, in accordance with the resident's care plan and policy. [s. 36.]

Additional Required Actions:

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

Issued on this 30th day of May, 2018

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) :	KATHERINE BARCA (625), AMY GEAUVREAU (642), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2018_703625_0007
Log No. / No de registre :	001520-18, 001524-18, 001531-18, 001533-18, 005318-18, 005320-18, 005321-18, 005322-18, 005327-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 25, 2018
Licensee / Titulaire de permis :	Riverside Health Care Facilities Inc. 110 Victoria Avenue, FORT FRANCES, ON, P9A-2B7
LTC Home / Foyer de SLD :	Rainycrest 550 Osborne Street, FORT FRANCES, ON, P9A-3T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marva Griffiths

To Riverside Health Care Facilities Inc., 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)

Linked to Existing Order / Lien vers ordre existant: 2017_624196_0016, CO #001;

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 comply with s. 6 (7) of the Long-Term Care Homes Act, 2007.

The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee shall specifically ensure that:
(a) toileting is provided to resident #002, and to all residents in the home, as per their plans of care;
(b) bathing and falls prevention interventions are provided to resident #005, and to all residents in the home, as per their plans of care;
(c) responsive behaviours interventions are provided to resident #006, and to all residents in the home, as per their plans of care; and
(d) skin and wound care treatments and assessments are completed for residents #012 and #013, and all residents in the home, as per their plans of care.

Grounds / Motifs :

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

A complaint was received by the Director regarding the care of resident #002. The complaint alleged that toileting was not being provided as per the resident's plan of care due to staffing shortages.

During an interview with Inspector #617, the complainant reported that they

witnessed resident #002 wait for a prolonged period of time to be assisted to the toilet. The complainant explained that the resident required the assistance of staff and was not able to toilet themself.

A review of resident #002's care plan dated the winter of 2018, indicated that the resident required the assistance of staff with toileting at a specific frequency, and that staff were to document the care provided on a document initiated in the spring of 2018.

Inspector #617 reviewed the document listing the dates and times the resident was to be toileted, and instructions for staff to record when the resident was toileted, on the document. The documentation indicated that, over a period of 12 days in the spring of 2018, documentation of resident #002's toileting was missing 61 per cent of the time,

During interviews with RPN #129 and PSWs #147 and #146, they confirmed to the Inspector that resident #002 required staff assistance with a component of toileting, was to be toileted at a particular frequency and staff were to record the toileting on the document in use. In a separate interview with PSW #147, they reported that when the unit was short staffed, there was not enough staff to provide the required staff assistance to the resident and, as a result, the resident's toileting may have been missed at the required frequency.

In an interview with the DOC, they reviewed the document detailing resident #002's toileting over the 12 day period and confirmed to the Inspector that there were several times documentation was missing, which indicated that the staff were not following the resident's care plan and toileting the resident at the required frequency. (625)

2. The following is further evidence to support CO #001 issued on January 10, 2018, during RQI #2017_624196_0016, with a compliance due date of February 28, 2018. Grounds supporting CO #001 were identified specifically related to resident #005 being transferred in a manner other than that detailed in their care plan.

A complaint was received by the Director related to alleged abuse and neglect of resident #005.

Inspector #625 reviewed a Critical Incident System (CIS) report that identified

that resident #005 requested the assistance of the home's staff multiple times over a period of time before PSW #124 assisted the resident.

The home's investigation file identified that PSW #124 had transferred resident #005 in an unsafe manner. The alleged incident occurred several weeks after the home was served CO #001 in the above mentioned report, which included supportive grounds for resident #005 being transferred in a manner other than that detailed in their plan of care.

A review of the resident #005's ADL Assistance care plan identified that the resident required staff assistance to transfer.

During an interview with Inspector #625, the DOC stated that PSW #124 assisted resident #005 to transfer in a manner other than that detailed in the resident's care plan. The DOC acknowledged that the home had a current order from inspection report #2017_624196_0016 related to resident #005's transferring and that the care set out in resident #005's plan of care had not been provided to the resident, with respect to transferring the resident, at the time of the incident. (625)

3. A complaint was received by the Director regarding a fall experienced by resident #005.

Inspector #625 reviewed resident #005's electronic progress notes which identified the resident fell, while using a mobility aid, during the winter and spring of 2018. A note related to the fall in the spring of 2018, identified that the resident's care plan indicated the resident required a falls prevention item to be used when using their mobility aid, but that the item had not been utilized.

Inspector #625 reviewed resident #005's care plan titled Falls, last updated in the spring of 2018. The care plan contained an intervention dated several years prior, that identified the resident required the falls prevention item when using their mobility aid. The care plan also included an intervention entered the day after their fall in the spring of 2018, that identified the resident was issued another falls prevention item to use with their mobility aid as they did not have one in place.

During an interview with RN #114, they stated that resident #005's falls usually occurred when using their mobility aid in a specific manner. The RN

acknowledged that the resident's care plan identified that they required the falls prevention item over the last few years, but the progress notes identified that the item was not in use with the mobility aid when the resident fell in the spring of 2018. The RN stated that care set out in resident #005's care plan was not provided to the resident with respect to the use of the falls prevention item with their mobility aid.

During an interview with Inspector #625, the DOC stated that, according to resident #005's care plan and progress notes, they did not have the falls prevention item in use with their mobility aid when they fell in the spring of 2018, but required one. The DOC acknowledged that resident #005 did not have the care set out in their plan of care provided, with respect to the use of the falls prevention item with their mobility aid. (625)

4. CO #001 was issued from inspection #2018_509627_0004 pursuant to Ontario Regulation 79/10, s. 31. (3) (a). The order required the home to develop, implement and maintain records for an auditing process to ensure that when working short staffed, all resident care that was missed was followed up with, with a compliance date of April 15, 2018.

Inspector #625 reviewed an ONA/Long-Term Care Professional Responsibility (PRW) Report Form which detailed that, due to staffing shortages, on a particular date in April 2018, over a specific shift, "All treatments not completed on both [two units]". The document identified that, on that date, the home:
- had one Registered Nurse (RN) [from a complement of 2] over four hours during the shift;
- was short six PSWs on the previous shift [from a complement of 14 full and two partial shifts], had two PSWs on one unit for four hours [from a complement of five full shifts and one partial shift], had two PSWs on another unit for the entire shift [from a complement of four PSWs]; and
- did not have a Registered Practical Nurse (RPN) show up for work at a particular time [from a complement of five RPNs].

The Inspector reviewed a spreadsheet titled Nursing Shortage Hours which identified the home was short 11.25 RN/RPN hours and 60 PSW hours on that particular date in April 2018.

The Inspector reviewed the Rainycrest Wound Auditing Sheet for one unit for one week in April 2018, which had been completed five days after the audited

week had ended, by RN #130, the home's Skin and Wound Care Lead. The audit identified that one weekly progress note was missing for resident #007, but did not identify any other missed treatment components.

Inspector #625 reviewed the Treatment Record – Long Term Care for resident #012 which identified, with respect to the resident's altered skin integrity, the RN was to complete an intervention at a specific frequency on a particular day of the week. The corresponding evaluation notes did not include an entry for a particular date in April 2018, and the resident's GoldCare progress notes did not contain any documentation on the intervention that was to have occurred on that date.

The Inspector also reviewed resident #013's Treatment Record – Long Term Care which identified the resident's area of altered skin integrity required an intervention to be completed at a specified frequency. The corresponding evaluation notes did not include entries reflecting the intervention had been completed on three particular dates in April 2018.

During an interview with the home's Skin and Wound Care Lead, RN #130, they stated that staff were required to document daily on the Treatment Record – Long Term Care form and weekly in a GoldCare progress note. The RN indicated that a lack of completion of wound care would be evident on the treatment record. The RN acknowledged resident #012's treatment record did not contain documentation that an intervention was completed on a date in April 2018, and resident #013's treatment record did not include a note for the required intervention on three dates in April 2018. The RN identified that the treatments had not been completed if a corresponding note was not present on the treatment record.

During an interview with Inspector #625, the ADOC stated that RN #130 completed the skin and wound care audits. The ADOC acknowledged that, as the RN had not completed an audit for missed skin and wound treatment related care for one particular week in April until five days after the week ended, the RN would not be able to go back and ensure that resident care that was missed was followed up with and completed as required. The ADOC also acknowledged that the missed intervention for resident #012 on a date in April, had not been identified during the audit that occurred by the RN, as that date had not yet been audited with an opportunity to address deficiencies in resident care not completed due to staffing shortages. (625)

5. CO #001 was issued from inspection #2017_624196_0016 pursuant to the Long-Term Care Homes Act (LTCHA), 2007 S.O. 2007, c.8, s. 6. (7).

The licensee was ordered to:
a) Ensure skin and wound care was provided to resident #014, and to all residents in the home, as specified in their plans of care;
b) Ensure that:
1) resident #005 was provided with bathing and transferring specific to their designated plan of care,
2) resident #006 was provided with the interventions specified within their plan of care to manage their responsive behaviours,
3) resident #004 was provided with transferring techniques, as specified in their respective plan of care, and
c) Ensure that all resident care, set out in the plan of care, was provided to the resident as specified in the plan.

The compliance date was February 28, 2018.

The licensee completed section a) in ensuring that resident #014 was provided with skin and wound care; and areas of section b) in ensuring resident #004 was provided with transferring techniques specific to their care plan.

The licensee failed to complete areas of section b) in ensuring that resident #005 was provided with bathing and resident #006 was provided with responsive behaviour interventions specific to their plans of care.

Inspector #617 reviewed resident #006's care plan dated a particular date in the winter of 2018, which indicated that the resident exhibited responsive behaviours related to a medical diagnosis and specific characteristics exhibited. A description of the behaviours and triggers were identified in the care plan. Interventions indicated that the staff who provided a particular type of staffing were to document, at a specific frequency, the resident's responsive behaviours on the resident's health care record to capture behavioural triggers.

A review of resident #006's physician's orders dated the fall of 2017, identified that the staff were to track the resident's behaviours on the resident's health care record at a specific frequency, and a particular level of staffing was to be provided, due to an interaction involving another resident that had occurred.

In an interview with PSW #150 they reported that, according to resident #006's care plan and physician's orders, staff who provided the particular level of staffing were required to document the resident's behaviours at a specified frequency. The PSW further explained that resident #006's behaviours were to be documented in a two specific locations in the resident's health care record.

Inspector #617 reviewed the schedule of the ordered staffing level provided to resident #006 over 55 days in the winter to spring of 2018, which identified that the resident did receive the ordered staffing level during that period of time.

A review of resident #006's PSW Flow Sheet documentation, dated from the winter to the spring of 2018, identified that 30 per cent of the shifts requiring behavioural documentation had not been completed by staff providing the ordered staffing level as per the plan of care.

A review of an additional document in resident #006's health care record, dated from the winter to the spring of 2018, identified that 18 per cent of the shifts did not contain the required documentation by the staff who had provided the ordered level of staffing to resident #006.

In an interview with the DOC, the DOC reviewed resident #006's documentation of their behaviours and confirmed that the staff who provided the ordered level of staffing were required to document the resident's behaviours, and documentation was missing where the staff failed to provide the care as set out in the plan of care. (617)

6. CO #001 was issued from inspection #2017_624196_0016 pursuant to the LTCHA, 2007 S.O. 2007, c.8, s. 6. (7). Part b) of the order directed the home to ensure that resident #005 was provided with bathing as specified in their plan of care, with a compliance date of February 28, 2018.

The licensee failed to complete areas of section b) in ensuring that resident #005 was provided with bathing interventions specific to their plan of care.

Inspector #617 reviewed resident #005's care plan last updated in the winter of 2018, which identified that the resident required staff assistance with transferring and bathing, using transfer equipment.

A review of the documentation of the care provided to resident #005, specific to bathing, on their PSW Flow Sheet, indicated that between two dates in the spring of 2018, over a period of ten days, the resident received one bath.

A review of the unit's bath schedules indicated that resident #005 was scheduled to receive their bath on particular shifts twice weekly. The resident had received one bath during this period of ten days.

A review of the Head to Toe Assessment completed by the PSWs did not indicate that the resident had refused a bath over multiple days within the ten day period.

In an interview with resident #005 they reported to the Inspector that they have baths at a particular frequency on two specific days of the week, depending on the staffing. The resident reported that in April they had missed their a bath because the unit was short staffed. The resident explained that they relied on staff assistance to bathe.

During interviews with PSWs #148 and #149, they reported to the Inspector that resident #005 was scheduled to have their baths at a particular frequency on specific shifts. Both PSWs reported that resident #005 required assistance from staff with bathing activities. PSW #149 confirmed to the Inspector that on a date in April 2018, resident #005 had missed their bath on a shift due to short staffing on the unit. The PSW further explained that the contingency plan required the following shift on that date to provide the missed bath, however; the unit was short staffed on the following shift and was unable to provide the bath.

In an interview with Receptionist #135 they confirmed to Inspector #617 that on a particular date in the spring of 2018, the unit worked with multiple PSWs shortages on two particular consecutive shifts.

In an interview with the Director of Care (DOC), both the Inspector and the DOC reviewed resident #005's flow sheet and Head to Toe Assessments. The DOC confirmed that resident #005 had missed a bath, and was not provided with their scheduled bath as specified in their plan of care.

The licensee's history of non-compliance pursuant to s. 6 (7) is as follows:
- During Follow-up inspections #2017_624196_0016 and #2017_435621_0011, commencing on November 20, 2017, and March 31, 2017, respectively, a

Director Referral (DR) and a Compliance Order (CO) were issued;
- During Resident Quality Inspections (RQIs) #2017_463616_0011 and #2016_463616_0026, commencing on July 17, 2017, and November 14, 2016, respectively, and during CIS inspection #2016_339617_0021, commencing on May 30, 2016, a CO was issued;.
- During Critical Incident System (CIS) inspection #2017_395613_0001, commencing on January 9, 2017, a Voluntary Plan of Correction (VPC) was issued; and
- During Complaint inspection #2016_320612_0018, commencing on June 20, 2016, a Written Notification (WN) was issued.

The decision to reissue this CO and DR was based on the severity which indicated the presence of actual harm or risk, and the scope which identified a pattern of occurrence. In addition, the home's compliance history (specifically the outstanding CO and DR, the issuance of two previous DRs, five previous COs, one VPC and one WN) demonstrates the home's inability to maintain compliance in this area of the legislation. (617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 02, 2018

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

Order / Ordre :

The licensee must be compliant with s. 31. (3) of Ontario Regulation 79/10.

The licensee shall ensure that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

The licensee shall specifically:
(a) Review, revise and implement the home's staffing plan to ensure that assessed resident care and safety needs are met;
(b) Recruit and retain staff to fill staffing vacancies and reduce the amount of nursing shortage hours;
(c) Develop and implement daily audits to ensure that, when working short staffed, all resident care that is missed is made up in a timely manner, as appropriate. Care that shall be audited includes, but is not limited to, the completion of skin and wound care treatments and assessments; the provision of beverages and snacks; the bathing of residents as per their preferred type and frequency of bathing detailed in their plans of care.
(d) Maintain records of the audits and the actions taken to rectify identified deficiencies.The records shall include the date, time, location, residents involved, staff involved, the name and classification of the person making the observation, any actions taken and the outcome.
(e) Develop and implement routine monitoring processes for the toileting of residents and the bedtime and rest routines of residents.
(f) Maintain records of the monitoring processes and the actions taken to rectify identified deficiencies. The records shall include the date, time, location, residents involved, staff involved, the name and classification of the person making the observation, any actions taken and the outcome.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation.

The licensee has failed to comply with CO #001 from inspection #2018_509617_0004 served on March 15, 2018, with a compliance date of April 15, 2018.

The licensee was ordered to:
A) Review, revise and implement their staffing plan to ensure that assessed

resident care and safety needs are met;
B) Recruit and retain staff to fill all staffing vacancies and reduce the amount of nursing shortage hours;
C) Develop, implement, and maintain records for an auditing process to ensure that when working short staffed, all resident care that is missed is followed up with;
D) Improve the communication between staff and management to determine gaps in providing resident care, safety issues, and actions taken by providing and recording monthly staff meetings.

The licensee completed part D in CO #001.

The licensee failed to completed parts A, B and C regarding the staffing plan, staffing vacancies and auditing processes.

(A) With respect to part A, the licensee was ordered to review, revise and implement their staffing plan to ensure that assessed resident care and safety needs were met.

Inspector #625 reviewed documents provided by the home's Administrator and DOC related to part A of the order including a Staffing Evaluation Plan that identified the home had the following staff complement:

(a) on the day shift one unit had three registered nursing staff and eight PSWs; another unit had three registered nursing staff and six PSWs; and a third unit had two registered nursing staff, two PSWs and two additional staff providing ordered enhanced staffing.

(b) on the evening shift one unit had two registered nursing staff and six PSWs; another unit had three registered staff and four PSWs; and a third unit had one registered staff, two PSWs and two additional staff providing ordered enhanced staffing.

(c) on the night shift one unit had one registered nursing staff and two PSWs; another unit had one registered nursing staff and two PSWs and a third unit had no specifically designated registered nursing staff, two PSWs and two additional staff providing ordered enhanced staffing.

The plan also identified that the back-up plan to address staff shortages was reviewed on February 29, 2018, and was used continuously due to staff shortages.

The Inspector also reviewed a document titled Nursing – Staffing Contingency

Plan - Rainycrest, which had been reviewed by the home and updated to address the order. Both the current and previous versions identified that, if the home was working with two or more PSWs short, staff were to "Prioritize baths, down grade bath to bed bath. If a bath is missed, staff on next shift to be made aware so they can pick it up."

The Inspector reviewed a document titled Rainycrest – Recommended change in staff ratio compared LTC average in similar # of beds, dated April 20, 2018, that compared the home's staffing levels to average staffing levels in long term care. The document identified, when fully staffed and with no resident vacancies:

(a) one unit, comprised of 84 resident beds, had eight PSWs to work day shift, compared to an average of eight to ten PSWs; six PSWs to work evening shift, compared to an average of seven to eight PSWs; and two PSWs to work night shift, compared to an average of 2.5 to three PSWs;

(b) another unit, comprised of 59 resident beds, had six PSWs to work day shift, compared to an average of six to seven PSWs; four PSWs to work evening shift, compared to an average of five to six PSWs; and two PSWs to work night shift, compared to an average of two PSWs; and

(c) a third unit, comprised of 21 resident beds, had two PSWs to work day shift, compared to an average of 2.5 to three PSWs; two PSWs to work evening shift, compared to an average of 2.5 to three PSWs, and two PSWs to work night shift compared to an average of one PSW. The document did not include the ordered enhanced staffing present on the third unit during each shift.
The document identified that consideration was being taken to increase staffing levels on the two of the units.

Inspector #625 also reviewed meeting minutes from an ONA Labour Management Meeting held on April 24, 2018, which identified the revised contingency plan had been implemented and placed in the scheduling binder; ONA representative #133 indicated that the contingency plan was not working; and RN #134 identified there was no email advising that the amended contingency plan was placed in the binder.

During an interview with Receptionist #135, they stated they completed the scheduling of vacant shifts, with a focus on the day-to-day and short notice coverage of shifts. When asked if they were familiar with the revised Nursing – Staffing Contingency Plan – Rainycrest document, the Receptionist stated that they had not seen the plan until approached by the Inspector four days after the

order was due, and would not have known that the plan had changed as they were not told that it had changed or of the specific changes made.

During an interview with Administrative Assistant #136, they stated that they did day-to-day staffing when assisting Receptionist #135, or if the Receptionist was not present and they were providing coverage. The Administrative Assistant stated they were not familiar with the staffing contingency plan in its entirety.

During an interview with RN #114, they stated that they were aware of the existence of the home's staffing contingency plan document and that it was located in the scheduling binder, but that that they were not aware if the plan had been updated and would follow the instructions provided to them by Receptionist #135 when redistributing staff during staffing shortages.

During an interview with RN #137, they stated that they had not been notified that the staffing contingency plan had been changed.

During an interview with RN #113, they stated that, at times, they were responsible to call in staff. The RN stated that they were familiar with the staff contingency plan and noted "one side can be short on even days, the other side the opposite". [This direction was listed on the former plan for shortage of one PSW but had been removed from the revised plan.]

During an interview with Inspector #625, the Administrator discussed the review of the home's staffing plan and identified that consideration to increase the staffing ratios during the evening and night shifts on two of the units had not been implemented. The Administrator acknowledged that the home had reviewed their staffing plan and identified areas where staffing levels could be improved, but that the home had not revised or implemented the changes to the staffing plan as they continued to work on recruiting staff.

The license failed to complete part (A) of the order as the home had not revised or implemented changes to the staffing plan to ensure that assessed resident care and safety needs were met.

(B) With respect to part B, the licensee was ordered to recruit and retain staff to fill all staffing vacancies and reduce the amount of nursing shortage hours.

(i) Staffing Vacancies

Inspector #625 reviewed documents provided by Administrative Assistant #136 (who completed long term and advanced scheduling replacement) and identified:
- the full staffing complement in the home consisted of:
(a) RNs – two full time Unit Coordinators, four full time floats and four part time staff;
(b) RPNs – 12 full time and seven part time staff; and
(c) PSWs – 39 full time and 11 part time staff.
- On February 9, 2018, the last day of inspection #2018_509617_0004, the home had two part time RN vacancies. On March 15, 2018, the day the home was served CO #001 from inspection #2018_509617_0004, the home had one full time and two part time RN vacancies. On April 15, 2018, the day CO #001 was due, the home had one full time and two part time RN vacancies. The home had not hired any new RNs from February 9 to April 15, 2018.
- On February 9, 2018, the home had one full time and two part time RPN vacancies. On March 15, 2018, the home had two part time RPN vacancies. On April 15, 2018, the home had two part time RPN vacancies. The home had hired one casual RPN in February, one full time RPN in February and one agency RPN in March 2018.
- On February 9, 2018, the home had eight full time PSW vacancies. On March 15, 2018, the home had six full time PSW vacancies and one part time PSW vacancy. On April 15, 2018, the home had eight full time and four part time PSW vacancies. The home had hired one full time PSW in April (prior to the compliance date), two casual PSWs in April (after the compliance date) and one full time PSW in April 2018 (after the compliance date).

The Inspector reviewed the home's staffing schedules which were consistent with the documents provided by Administrative Assistant #136, which indicated that, as of April 15, 2018, the home had one full time and two part time RN vacancies; two part time RPN vacancies; and eight full time and four part time PSW vacancies.

During an interview with Administrative Assistant #136, they acknowledged the vacancies as identified on the staff schedule.

During an interview with the DOC, they acknowledged the home had vacant positions including one full time and one part time RN, two part time RPNs, and multiple full and part time PSWs.

During an interview with the home's Administrator, they provided a document to the Inspector they stated originated from their Human Resources Department, which identified staffing vacancies as two part time RNs, two part time RPNs, three full time PSWs and four part time PSWs. The Administrator was not able to explain why the number of staffing vacancies on the document supplied by the Human Resources Department differed from the information located on the home's staff schedules and the information provided by the Administrative Assistant. The Administrator stated that they "haven't laid anyone off" but acknowledged the home continued to experience staffing vacancies in the RN, RPN and PSW classifications and that, with respect to part B of CO #001, all components had not been completed, as the home still needed to do some other things and implement some things.

(ii) Nursing Shortage Hours
Inspector #625 reviewed the document Nursing Current Staffing maintained and provided by Administrative Assistant #136. The document identified the daily staffing complement in place in the home as 45 RN hours per day on weekdays and 37.5 RN hours per day on weekends; 82.75 RPN hours per day; and 248.5 PSW hours per day.

Inspector #625 reviewed a spreadsheet titled Nursing Shortage Hours, compiled by Receptionist #135, which identified the number of staffing hours short per day for registered staff and PSWs, from January 1 to April 25, 2018. The document identified the home experienced the following staffing shortages:
- in January 2018 the home was short 67.25 registered nursing staff hours and 640.5 PSW hours (with an average of 20.7 PSW hours short per day and a daily maximum of 55.5 PSW hours short). The total staff hours short was 707.75 hours, for a daily average of 22.8 hours.
- in February 2018 the home was short 65.5 registered nursing staff hours and 593 PSW hours (with an average of 21.2 PSW hours short per day and a daily maximum of 58 PSW hours short). The total staff hours short was 658.5 hours, for a daily average of 23.5 hours.
- in March 2018 the home was short 44 registered nursing staff hours and 802 PSW hours (with an average of 25.8 PSW hours short per day and a daily maximum number of 58 PSW hours short). The total staff hours short was 846 hours, for a daily average of 27.3 hours.
- from April 1 to 14, 2018, the home was short 38.25 registered nursing staff hours and 465.5 PSW hours (with an average of 33.25 PSW hours short per day and a daily maximum number of 61 PSW hours short). The total staff hours

short was 503.75 hours, for a daily average of 36 hours.

The Inspector reviewed the spreadsheet with a focus on the shortages experienced after the compliance date of April 15, 2018, and determined that, from April 15 to 25, 2018, the home was short 22.75 registered nursing staff hours and 308 PSW hours (with an average of 28 PSW hours short per day and a daily maximum number of 60 PSW hours short). The total staff hours short was 330.75 hours, for a daily average of 30 hours. The Inspector noted that the average daily number of nursing shortage hours had not been reduced from the period of time of inspection #2018_509617_0004 in February 2018, to the period of time CO #001 was served to the home in March 2018, to the most recent data analyzed from April 15 to 25, 2018.

Inspector reviewed the Riverside Health Care Facilities – Rainycrest Staffing Document used by the home's management team to document and track daily forecasted and actual staff absences. The Inspector noted that, on April 16, the document identified the home had been short 2.5 PSW shifts, or 18.75 hours, and that dietary staff assisted with evening snack pass. When the Inspector compared the document to the Nursing Shortage Hours maintained by Receptionist #135, it was identified that the values tracked differed as the document listed that the home had been short 33 PSW hours on April 16, 2018. The Inspector noted that the hours listed on other dates were also inconsistent between the two documents.

During an interview with the DOC, they stated that the home's management and administration maintained the document titled Riverside Health Care Facilities – Rainycrest Staffing Document. The DOC indicated the number of PSW staff shortage hours reflected on the document on April 15, 2018, 5.5 PSWs, or 41.25 hours, differed from that tracked by Receptionist #135 on the Nursing Shortage Hours spreadsheet, which identified the home had been short 44 PSW hours that date. The DOC stated that the Riverside Health Care Facilities – Rainycrest Staffing Document had reflected the use of supplemental staff [non-PSW staff from other departments who could assist with activities on the unit other than personal care].

During an interview with the Administrator, they stated that, with respect to the nursing shortage hours experienced by the home, the home had been in a gastric outbreak from February 13 to March 5, 2018, and were currently experiencing a respiratory outbreak that began on April 5, 2018. The

Administrator stated the home continued to experience nursing shortage hours, including those due to sick calls, and that recruitment efforts were being made.

The licensee failed to complete part (B) of the order as the home failed to recruit and retain staff to fill all staffing vacancies and reduce the amount of nursing shortage hours.

(C) With respect to part C, the licensee was ordered to develop, implement, and maintain records for an auditing process to ensure that when working short staffed, all resident care that was missed was followed up with.

(i) The home had failed to develop, implement and maintain records for auditing of skin and wound care treatments to ensure that when working short staffed, all resident care that was missed, with respect to skin and wound care treatments, was followed up with.

A review of an ONA/Long-Term Care Professional Responsibility (PRW) Report Form by Inspector #625 identified that, due to staffing shortages on a date in April 2018, all treatments had not been completed on two units.

The Treatment Records – Long Term Care did not identify that resident #012 had an intervention for altered skin integrity completed, at a specified frequency, on the date identified on the ONA form; or that resident #013 had skin and wound care treatments completed on the date identified on the ONA form, as well as on two additional dates.

A review of the Nursing Shortage Hours spreadsheet for the date identified on the ONA form, identified that the home worked with a shortage of 11.25 registered nursing staff hours [out of 37.5 hours] and 60 PSW hours [out of 248.5 hours] that day.

Inspector #625 reviewed a Rainycrest Wound Auditing Sheet for a particular unit for one week in April 2018, which had been completed five days after the end of that week, by RN #130, the home's Skin and Wound Care Lead. The audit did not identify the missed treatments on the two additional dates in April when resident #013 had missed the interventions, and did not include any treatments missed during the five days between the end of the audited dates and the date of the audit (specifically the missed interventions for residents #012 and #013 that occurred on the day following the last date included in the weekly audit).

During an interview with Inspector #625, RN #130 acknowledged that resident #013's skin and wound care intervention to be completed at a specific frequency had not occurred on three dates in April 2018, and resident #012's skin and wound care intervention had not been completed on a date in April 2018. The RN acknowledged that the skin and wound care interventions should have been completed but had not been audited, identified and/or addressed as of a date in April 2018.

See Written Notification (WN) #1, finding #4, for details.

(ii) The home had failed to develop, implement and maintain records for auditing of the provision of beverages and snacks to ensure that when working short staffed, all resident care that was missed, with respect to the provision of beverages and snacks, was followed up with.

During interviews with PSW #105, they stated that, since April 15, 2018, the snack cart had not been distributed to residents on numerous occasions as there were not enough staff to ensure the distribution of the snacks as well as ensure the residents were toileted, kept dry and helped to the bathroom.

During interviews with PSWs #131, #132 and #124 and RPN #129, they stated that they had been working with staff shortages on specific dates since April 15, 2018, and that all components of resident care could not be completed when they worked short. PSWs #124 and #131 and RPN #129 identified that the Activation and/or Dietary departments had completed nourishment passes on the identified dates the PSW staff worked short. PSWs #124, #131 and RPN #129 acknowledged that the other departments did not and/or had not signed PSW Flow Sheets to reflect the distribution of the snack passes they had provided. PSW #131 stated that Activation staff "usually tell us if someone hasn't taken a snack" and RPN #129 stated staff from the Activation and Dietary departments did not know the names of some of the residents but would point them out and say "these two didn't take anything".

See WN # 1, finding #8, for details.

(iii) Although the home had developed, implemented and maintained records for auditing of bathing of residents, the process in place failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents'

assessed care and safety needs and that met the requirements set out in the Act and this Regulation with respect to bathing. The home failed to ensure that, when the home worked with less than the full complement of staff, residents were bathed twice a week by the method of their choice, where "bathing" included tub baths, showers, and full body sponge baths.

Inspector #625 reviewed a document titled Nursing – Staffing Contingency Plan - Rainycrest, which identified that, if the home was working with two or more PSWs short, staff were to "Prioritize baths, down grade bath to bed bath. If a bath is missed, staff on next shift to be made aware so they can pick it up."

During an interview with PSW #138, they stated that, on a date in April 2018, one unit had been short three PSWs on days shift [out of 8] and only had two PSWs instead of six on evenings. The PSW stated the home's management told the staff that baths had to be completed, even bed baths. The PSW indicated that the staff just washed residents' armpits and groin but that was not the same as a bath to the PSW. The PSW noted that the staff document this type of limited bath provided as a bed bath and that staff were not able to make up missed baths on the following shifts when the following shift was also working short.

During an interview with PSW #105, they stated that resident baths were not getting completed all the time as "there isn't a day when we aren't short staffed. There is no way possible that, when we're working short, we can pick up baths from the previous shift. When we do pick them up, people are getting baths back-to-back, two days in a row and then not bathed for another week". The PSW stated that some residents had been given bed baths and "they weren't happy" about it. The PSW identified that resident #036 did not receive a bath on a date in April 2018, and had been rescheduled to the following day, but did not receive that bath either. The PSW identified that the resident had a particular type of bath on two dates in April, and a different type of bath on a third date in April, although their care plan identified they were to have a different type of bath than that provided on the third date. The PSW also identified that resident #037 did not have a bath on a date in April as there were three PSWs on day shift instead of 5.5. The PSW identified that the resident's bath had not been made up the following day and their next scheduled bath was due three days after their missed bath.

Inspector #625 reviewed the Bath Schedule Days and identified that resident

#036 was to bathe at a specified frequency, resident #036's current care plan that identified they were to have a particular type of bath and required staff assistance, their Head to Toe that had skin assessments [to be completed with each bath] documented on two dates in April, the PSW Flow Sheets that listed the resident had a specific type of bath on two dates in April and a different type of bath, which differed from that listed in their care plan, on a third date in April, and Gold Care progress notes that had no documentation related to the resident's bathing.

Inspector reviewed the Bath Schedule Days and identified that resident #037 was to bathe at a specified frequency, resident #037's current care plan that identified the resident's preferred method of bathing and that the resident required staff assistance, their Head to Toe which was last completed on a date in April, the PSW Flow Sheets that listed the resident had a specific type of bath five days earlier, and Gold Care progress notes that had no documentation related to the resident's missed bath.

During an interview with PSW #128, they stated residents who required the use of a particular type of transfer equipment were being given bed baths instead of tub baths if the unit worked short.

During an interview with RPN #129, they stated that working short resulted in residents not being provided with time to do activities of daily living independently, as the staff completed the activities for the residents so that items such as bathing and washing could occur. The RPN stated "We don't prompt or cue, just do it so that they do have care". The RPN identified that many baths were being missed and were not always made up as the next shift, which was expected to make up the missed baths, was working short too. The RPN identified that resident #038 had their last bath on a date in April and had not had a bath since then, seven days later, as per the documentation on the PSW Flow Sheets and Head to Toe Assessment. The RPN identified that the resident was supposed to have a bath on a date in April, and it was written to make up to bath on the following date, but that it was not checked off as completed.

Inspector #625 reviewed the Bath Schedule Days and identified that resident #038 was to bathe at a specific frequency, resident #038's current care plan that identified they were to bathe in a particular manner and required staff assistance, their Head To Toe that had a skin assessment documented last on a

date in April, the PSW Flow Sheets that listed the resident bathed in a manner other than that listed in their care plan on a date in April, and Gold Care progress notes that had no documentation related to the resident's missed bathing.

During an interview with PSW #124, they stated that the auditing and follow-up of bathing residents has been incorrect, as one resident noted for a make-up bath in the unit calendar was bathed twice.

During an interview with PSW #139, they acknowledged that some residents were provided with baths on two consecutive days in an effort to make up a missed bath.

During an interview with the ADOC, who conducted the bathing audits, they stated that resident #038 did not have the bath missed on a date in April 2018, made up. The ADOC indicated that they believed the resident had a sponge bath but did not know why a sponge bath was provided to the resident. The ADOC stated that resident #036 did not receive a specific type of bath on a date in April 2018, and had not had that type of bath made up. The ADOC was not able to identify why the resident was provided with a particular type of bath on April 21st, and stated that residents' preferences for bathing should be upheld. The ADOC also acknowledged that resident #037 had not been provided with their bath on a date in April 2018, and that, if the staff were able to make up the missed bath on that date, the resident would have not had a bath for five days, and would then have two baths in three days. The ADOC acknowledged that they were aware of some residents receiving make-up baths two days apart from their next scheduled bath. The ADOC acknowledged that it was not a best practice to provide baths at the altered frequency discussed and stated "that's when we could ask them to give a bed or sponge bath in the meantime".

The licensee failed to complete part (C) of the order as the home failed to develop, implement, and maintain records for an auditing process to ensure that when working short staffed, all resident care that was missed was followed up with, with respect to skin and wound care, the provision of beverages and snacks, and the provision of bathing as per residents' preferences and plans of care.

(D) Non-Compliance Pursuant to Ontario Regulation 79/10, s. 31 (3)

(i) The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation with respect the safe transferring and positioning devices or techniques when assisting residents with the use of mechanical lifts.

Inspector #617 reviewed the home's policy titled, "Minimal Lift Procedures-#ORG-III-NGE-15.01", last updated on January 30, 2018, which indicated that the use of a sit-to-stand mechanical lift required two persons to operate in which the second caregiver was given specific instruction on lowering the resident in the lift.

On a date in April 2018, Inspector #617 observed resident #002 being transferred by a PSW using a mechanical lift in an unsafe manner.

PSW #146 reported to Inspector #617 that they had performed the lift in an unsafe manner because the unit was short staffed.

Inspector #617 conducted an interview with Receptionist #135, in which both the Inspector and the receptionist reviewed the date of the incident nursing schedule. The Receptionist confirmed to the Inspector that the unit where resident #002 resided, was working one PSW short for the day shift. The unit was required to be staffed with five PSWs and there had been four PSWs providing care to the residents on the unit. [51 residents resided on the unit on the date of the incident].

During interviews with both RPN #129 and PSW #147, they both confirmed to Inspector #617 that resident #002 required the use of a mechanical lift which was to be operated in a specific manner to maintain safety.

In a separate interview with PSW #147, they reported to the Inspector that they had used the mechanical lift in an unsafe manner on several occasions for some of the residents due to the unit working short staffed, in an effort to maintain resident continence.

During an interview with Inspector #625, PSW #105 stated that, since April 15, 2018, when the home worked short staffed they had transferred residents using a mechanical lift in an unsafe manner. The PSW stated that they didn't want to do it but sometimes it couldn't be helped when there were only three staff on the

floor and someone may have gone for a break. They further stated that the transfers had to be completed in that way if the residents had to go to the bathroom as they "can't just let them sit there and wet themselves".

During an interview with Inspector #625, PSW #131 stated that, since April 15, 2018, they have worked with staff shortages of two, three or four PSWs out of eight PSWs on a day shift and out of six PSWs on an evening shift. The PSW identified that they had been responsible to provide care to approximately 30 resident on multiple consecutive dates after April 15. The PSW acknowledged that there were many mornings the staff transferred residents to toilet and to get up using a mechanical lift in an unsafe manner. The PSW stated that they knew it was not safe but in the long run they were trying to prevent a fall as residents had tried to crawl out of bed. The PSW further explained that one day three falls occurred in one hour as the PSW had been attempting to assist all of the residents but could not do so. The PSW stated that they have waited for 15 minutes for assistance from other staff with transfers, and then completed an unsafe transfer as the staff felt they were doing what was best for the resident.

During an interview with Inspector #625, PSW #132 stated that they used mechanical lifts in an unsafe manner when they worked short, and that if they knew the resident and their cognition, they would do it. The PSW identified that they had worked short every day since April 15, 2018, and specifically identified they worked multiple times with three out of six PSW staff on evening shifts, and had worked with one, two or three PSW staff short, out of eight PSWs, on day shifts.

See WN #4, finding #1, for details.

(ii) The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation, with respect to toileting residents.

During an interview with Inspector #625, PSW #124 stated that, since April 15, 2018, they had worked with less than the full staffing complement "most of the time". The PSW specifically identified that, on a date in April 2018, they had worked with a staff complement of four PSWs for six hours and two PSWs for two hours, on a unit where approximately 90 residents resided when fully occupied. The PSW stated that it was frustrating to them to be told to focus on

getting baths completed, which resulted in residents who needed to be toileted not being toileted or having to wait to be toileted. The PSW identified that residents who had been up before supper, sitting in the lounge, would have to wait until the staff put them to bed to be toileted. The PSW acknowledged that residents who required toileting before supper were not toileted if the home was short staffed.

During an interview with PSW #139, they also stated that residents who required toileting before supper were only toileted if they could ring for staff assistance and could wait for staff, but that the other residents had to wait until after supper to be toileted.

(iii) The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation, with respect to bed time and sleep routines.

During an interview with PSW #124, they stated that, on a date in April 2018, when they worked short on a unit in the home, two residents were still up at 2230 hours because the staff didn't have the time to put the residents to bed. The PSW stated that the residents had to wait for the night shift staff to arrive to assist them to bed.

Inspector #625 reviewed the Nursing Shortage Hours spreadsheet and identified that the home had worked with a shortage of PSW hours each day, out of a total of 248.5 daily PSW hours, since April 15, 2018 of:
- 44 PSW hours, or 18 per cent of the PSW hours, on April 15;
- 33 PSW hours, or 13 per cent of the PSW hours, on April 16;
- 29.5 PSW hours, or 12 per cent of the PSW hours, on April 17;
- 20 PSW hours, or 8 per cent of the PSW hours, on April 18;
- 22 PSW hours, or 9 per cent of the PSW hours, on April 19;
- 7 PSW hours, or 3 per cent of the PSW hours, on April 20;
- 26.5 PSW hours, or 11 per cent of the PSW hours, on April 21;
- 60 PSW hours, or 24 per cent of the PSW hours, on April 22;
- 40.5 PSW hours, or 16 per cent of the PSW hours, on April 23;
- 27 PSW hours, or 11 per cent of the PSW hours, on April 24; and
- 28 PSW hours, or 11 percent of the PSW hours, on April 25, 2018.

The licensee has failed to ensure that the staffing plan provided for a staffing mix

that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation, with respect to safe transferring techniques, the provision of toileting assistance and bed time and sleep routines.

During Complaint inspection #2018_509617_0004, commencing on January 30, 2018, a Director Referral (DR) and CO #001 were issued pursuant to r. 31 (3), as per the amendment to the report.

The decision to reissue this compliance order was based on the severity which indicated the presence of actual harm or risk, and the scope which identified a widespread pattern of a pervasive deficiency specific to this area of the legislation. In addition, the home's compliance history, specifically the outstanding CO and DR, determined the issuance of this order. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2018

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2018_509617_0004, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene;
(b) modes of infection transmission;
(c) cleaning and disinfection practices; and
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Order / Ordre :

The licensee must be compliant with s. 219. (4) of Ontario Regulation 79/10.

The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes hand hygiene, modes of infection transmission, cleaning and disinfection practices and use of personal protective equipment.

The licensee shall specifically:
(a) Provide annual training to all registered and direct care staff members regarding the home's written policies and the processes for hand hygiene, modes of infection and transmission, and the use of personal protective equipment (PPE) in accordance with Ontario Regulation 79/10, s. 219 (4); and
(b) Keep a record of the content of the training, the names of all staff who have completed the training, and the dates the training was completed.

Grounds / Motifs :

1. The Licensee has failed to ensure that the training and retraining for staff in infection prevention and control (IPAC) required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act was completed.

On February 20, 2018, CO #002 from inspection #2018_509617_0004 was issued pursuant to Ontario Regulation 79/10, s. 219. (4) (a).

The Licensee was ordered to:
1) Provide annual training to all registered and direct care staff members regarding the home's written policy and the process for hand hygiene, modes of infection and transmission, and use of personal protective equipment (PPE) in accordance with O. Reg. 79/10, s. 219 (4).
2) Keep a record of the education content, names of all staff trained, and dates when the training is completed.
3) Develop, implement, and maintain records for an auditing process to ensure that staff are performing proper hand hygiene and use of PPE; in addition, where the auditing process identifies performance issues, action is taken.

The compliance due date was February 28, 2018.

The licensee completed steps two and three of the order.

The licensee failed to complete step one of the order.

Inspector #642 reviewed the following documents:
- Surge Learning System, Public Health Ontario: Just Clean your Hands-Professional Staff, dated January 1, 2017, to April 24, 2018. The Inspector identified that 13 out of 145 direct care staff, or nine per cent of the direct care staff, had not completed the education required;
- Surge Learning System, Donning and Doffing of PPE with N95, dated January 1, 2017, to April 24, 2018. The Inspector identified that 10 out of 116 direct care staff, or nine per cent of the direct care staff, had not completed the education required; and
- Surge Learning System, Infection Prevention and Control Refresher, dated January 1, 2017, to April 24, 2018. The Inspector identified that 11 out of 145 direct care staff, or eight per cent of the direct care staff, had not completed the education required.

During interviews with PSWs #123, #125, and # 126, they stated they had not completed required education, which included the process for hand hygiene, modes of infection and transmission, and the use of personal protective equipment (PPE) by the due date.

Inspector #642 interviewed the Infection Control Practitioner who stated that the infection control education was only provided on Surge Learning, and not all the direct care staff had completed the education by April 15, 2018.

Inspector interviewed the DOC and the Administrator, who both stated that the IPAC education should have been completed by all direct care staff by the compliance date in the order, but that not all staff had completed the education as required, and that the completion of the required education was still outstanding for multiple staff.

The licensee failed to complete part one of CO #002, which required the home to train all direct care staff regarding the home's written policy and the process for hand hygiene, modes of infection and transmission, and the use of PPE. This portion of the order could not be complied.

During Complaint inspection #32018_509617_0004, commencing on January 30, 2018, CO #002 was issued with a compliance date of April 15, 2018.

The decision to re-issue a compliance order was based on the severity which indicated the potential for actual harm or risk to occur. Although the scope identified during this inspection was isolated, the home has a history of non-compliance specific to this area of the legislation, including an outstanding compliance order. (642)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 02, 2018

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s. 36 of Ontario Regulation 79/10.

The licensee shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee shall specifically:
(a) Ensure that all staff receive training in the safe and correct use of equipment, including mechanical lifts, prior to performing their responsibilities;
(b) Ensure that all staff receive retraining annually in the safe and correct use of equipment, including mechanical lifts;
(c) Develop and implement a routine monitoring process for the use of safe transferring techniques;
(d) Maintain records of the monitoring and the actions taken to rectify identified deficiencies. The records shall include the date, time, location, residents involved, staff involved, the name and classification of the person making the observation, any actions taken and the outcome.

Grounds / Motifs :

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

A complaint was submitted to the Director regarding the proper toileting of resident #002, when required.

On a date in April 2018, Inspector #617 observed PSW #146 transfer resident #002 using a mechanical lift in an unsafe manner. Resident #002's family member was in the room visiting at the time.

In an interview with PSW #146, they reported to the Inspector, that they had just assisted resident #002 using the mechanical lift, and explained that they had used the lift in an unsafe manner.

During an interview with resident #002's family member, they confirmed to the Inspector that they were in the room when PSW #146, used the mechanical lift in an unsafe manner. The family member explained that they had usually seen the lift used in a different manner than what they observed that day.

A review of resident #002's care plan dated the winter of 2018, indicated that the resident required staff assistance with transferring in a particular manner, using a mechanical lift. A review of the PSW Flow Sheet documentation of the care provided to the resident indicated that a mechanical lift was used in a particular manner to transfer the resident on certain shifts in April 2018. Documentation was missing for date in April when Inspector #617 observed the resident transferred in an unsafe manner.

In interviews with both RPN #129 and PSW #147, they both confirmed to the Inspector that resident #002 required the use of a mechanical lift to transfer, to be operated in a particular manner to maintain safety.

In a separate interview with PSW #147, they reported to the Inspector that they had used the mechanical lift, in an unsafe manner, on several occasions for some of the residents due to the unit working short staffed in an effort to maintain resident continence.

A review of the home's policy titled, "Minimal Lift Procedures-#ORG-III-NGE-15.01", last updated on January 30, 2018, indicated that the use of a sit-to-stand mechanical lift required two persons to operate in which the second caregiver was given specific instruction on lowering the resident in the lift.

In an interview with the DOC they confirmed that PSW #146 improperly transferred resident #002 by performing the lift in an unsafe manner and the lift should have been operated in a different manner for the resident's safety, in accordance with the resident's care plan and policy.

During CIS inspection #2017_624196_0017, commencing on November 20, 2017, a VPC was issued pursuant to r. 36.

The decision to issue this compliance order was based on the severity which indicated the potential for actual harm or risk, and the scope which identified a widespread pattern of occurrence. In addition, the home has a history of non-compliance related to this area of the legislation, issued pursuant to r. 36 and related non-compliance issued pursuant to s. 6 (7). (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2018

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
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 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) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	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 25th day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Katherine Barca

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