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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 31, 2018;	2018_655679_0022 (A3)	011366-18, 011385-18, 011392-18, 011399-18, 011411-18	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

Amended by MICHELLE BERARDI (679) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

An amendment has been granted to allow the Licensee to achieve management stability.

Issued on this 31 day of October 2018 (A3)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

Amended by MICHELLE BERARDI (679) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): July 16-20 and 23-26, 2018.

The following intakes were inspected upon during this Follow Up inspection:

- Four Follow up logs regarding CO's #001, #002, #003 and #004, issued during inspection #2018_703625_0007, regarding s. 6 (7) plan of care, r. 31 (3) staffing levels in the home, s. 219 (4), training for infection prevention and control and s. 36, safe transferring and positioning techniques.

- One Follow up log regarding CO #001, issued during inspection #2018_703625_0009, regarding s. 6 (4) (a), collaboration in the plan of care.

A Complaint inspection #2018_655679_0020 and a Critical Incident System Inspection #2018_655679_0021 were conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Physician, Registered Nurse Unit Coordinator, Infection Prevention and Control Practitioner, Chief Executive Officer (CEO) of Novo Peak Health, Financial Services, Occupational Health and Safety Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Administrative Assistant, Receptionist, Physiotherapy Assistants, Personal Support Workers (PSWs), Canadian Mental Health Association Outreach PSW, Support Workers, family members and

residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, complaint records, manufacturer instructions, as well as relevant policies.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Personal Support Services

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

Training and Orientation

During the course of the original inspection, Non-Compliances were issued.
3 WN(s)
0 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
O.Reg 79/10 s. 219. (4)	CO #003	2018_703625_0007	679

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. 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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.

During an interview with RPN #121 on July 17, 2018, they identified that some of the home’s PSW staff came to them on July 16, 2018, expressing confusion when reviewing resident #010’s plan of care, with respect to transfers. RPN #121 reported that resident #010 had a decline in the previous weeks and required a particular level of staff assistance with all transfers using a specific transfer device; no longer ambulated with a device, and used a different ambulation aid with a different level of staff assist for locomotion. RPN #121 verified that resident #010’s plan of care documentation was still identifying that the resident mobilized with a different device and required a different transfer device.

On review of resident #010’s Activities of Daily Living (ADL) Assistance care plan, Inspector #621 identified, under a specific section, that resident #010 mobilized

with the use of a specified device; required a specified level of assistance; required a specified transfer device, as required, for transfers; and as of a particular date, had pain on transfer with staff to use a specific device until condition improved. Additionally, under a separate section of the care plan, it identified that the resident needed a different level of staff assistance when using their mobility device.

During interviews with RN #106 and RPN #108, they confirmed with Inspector #621 that resident #010 had a significant change in their transfer ability, that the resident was no longer able to ambulate with a specified device and currently required a particular level of staff assistance for transfers. Both RN #106 and RPN #108 reviewed resident #010’s ADL Assistance care plan and confirmed that interventions in two areas of the care plan had conflicting information, and did not provide clear directions to staff and others who provided care to resident #010, which could put the resident at risk if staff attempted to mobilize the resident with a different mobility aid or attempted to transfer the resident with a different transfer aid.

During an interview with the Administrator, they confirmed to Inspector #621 that it was their expectation that the plan of care for each resident provided clear directions to staff and others providing direct care, with respect to transfer and locomotion needs. [s. 6. (1) (c)]

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

During inspection #2018_703625_0009, compliance order #001 was issued to the home to address the licensee's failure to comply with s. 6. (4) (a) of the Long Term Care Home's Act, 2007. The CO ordered the home to:

Ensure that the staff involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

The licensee was specifically ordered to:

(a) Conduct an audit of the residents in the home to ensure that their physiotherapy

assessments were current and had been completed as required, including initial assessments, quarterly assessments, reassessments following a change in resident status and assessments post-falls.

(b) For any residents identified that did not have a current physiotherapy assessment/reassessment, ensure that the assessment was completed.

(c) Develop and implement a tracking system that ensured that required physiotherapy assessments were completed and documented in GoldCare in a timely manner.

(d) Maintain records of the actions taken with respect to this order."

The compliance due date of this order was July 15, 2018.

The licensee completed part c and d of the compliance order; however, the licensee failed to complete part a and b.

1. In part "a" of the compliance order, the licensee was ordered to conduct an audit of the residents in the home to ensure that their physiotherapy assessments were current and had been completed as required, including initial assessments, quarterly assessments, reassessments following a change in resident status and assessments post-falls.

During a review of the home's documentation with respect to part "a" of the order, Inspector #621 identified a document titled "MOHLTC plan Order #1 Physio", that Novo Peak Health (NPH), a contract physiotherapy service provider, completed an audit of all residents currently in their physiotherapy program. The assessment included the date of referral, assessments completed since January 2018, the initial assessment date, and whether the resident was discharged from the program. The document however, did not identify that an audit was completed of all residents in the home.

During interviews with Physiotherapy Assistants (PTA's) #122 and #123, they reported to Inspector #621 that an audit had been completed to review the assessment and reassessment status of residents who were actively in a physiotherapy program with NPH since January 2018. PTA's #122 and #123 confirmed to the Inspector that the audit that had been completed for the compliance order did not include residents in the home who had not been referred

to NPH either on or after January 1, 2018. Further, PTA's #122 and #123 informed the Inspector that the home's staff were required to complete a referral using NPH's paper referral form before their Physiotherapist completed an assessment of a resident to determine eligibility for the program.

During an interview with the Chief Executive Officer (CEO) of NPH, they reported to Inspector #621 and #625 that based on their interpretation of the order, a decision was made to focus the audit on those residents in the home who had been referred by the home for physiotherapy assessment, and were already part of their program. The CEO reported to the Inspectors that they could run a report from a software program identified as Colligo, to determine the assessment status of those residents in the home who were not part of their program.

Inspector #621 reviewed the contract between NPH and the home, which identified that NPH became the contract service provider of Physiotherapy Services in the home effective November 1, 2016.

During a subsequent interview with PTA #122, they provided Inspector #621 with a record which identified that as of a particular date, 31 residents in the home who were not part of an active physiotherapy program with NPH, and of those, 13 residents had never had an initial assessment completed by NPH after they took over Physiotherapy Services in the home.

During an interview with the Administrator, they reported to Inspector #621 that it was their expectation that after NPH assumed the contract to provide Physiotherapy Services in the home, a baseline assessment had been completed of all residents, in order for NPH to independently determine whether residents not active in their program, continued to not require their program and services. As a consequence, the audit completed as part of the order did not include those residents who were not currently on the NPH program.

2. In part "b" of the order the licensee was ordered to ensure that an assessment was completed for any residents identified to not have a current physiotherapy assessment/reassessment.

During an interview with PTA #122, they reported to Inspector #621 that as of a particular date, there were 31 residents in the home who were not part of an active physiotherapy program with NPH, and of those, 13 residents never had an initial assessment completed after NPH took over Physiotherapy Services in the home in

late 2016. Additionally, PTA #122 identified that the program did not assess residents for eligibility to the program, unless a referral was made by the home to them.

During an interview with RN #106, they confirmed to Inspector #621 that NPH did not assess any resident unless the home's staff completed and sent the required Novo Peak referral form to the program. During a review of health records by RN #106, they confirmed the following for nine of the 13 residents identified by PTA #122 to have not been assessed by NPH after November 1, 2016:

- Resident #014 was admitted to the home on a particular date, and a NPH Physiotherapy (PT) referral was not sent to the program at any time after the resident's admission;

- Resident #015 was admitted on a particular date. Documentation identified that the home's former PT was involved with the resident until a particular date; however, there was no PT referral sent to NPH for re-assessment after a particular date. RN #106 identified that resident #015 would have benefited from a PT reassessment by NPH as the resident had specific diagnosis and had utilized a mobility aid since their admission;

- Resident #016 was admitted on a particular date, and no NPH PT referral was sent at any time after the resident's admission;

- Resident #009 was admitted on a particular date. Documentation identified that the home's former PT was involved with the resident until a specific date; however, there was no PT referral to NPH for re-assessment after a particular date. RN #106 identified that resident #009 would have benefited from a PT reassessment as the resident utilized a mobility aid.

- Resident #018 was admitted on a particular date. Documentation identified that the home's former PT was involved with the resident until a particular date. Additionally, there was no further documentation that the resident was discharged from PT services any time after a particular date, and there was no PT referral to NPH for re-assessment after a particular date. Further, RN #106 identified that resident #018 would have benefited from a PT re-assessment, as the resident utilized a mobility aid.

- Resident #019 was admitted on a particular date, with documentation identifying

that the home’s PT had been notified at that time. RN #106 confirmed that there was no further documentation from the home’s PT after a specific date, and that there was no PT referral sent to NPH for re-assessment after a particular date.

- Resident #020 was admitted on a particular date. Documentation identified that the home’s former PT was involved with the resident until a particular date; however, there was no record that the resident was discharged from PT services at any time thereafter. Additionally, there was no PT referral to NPH for reassessment of resident after a particular date. Further, RN #106 reported that resident #020 would have benefited from a PT reassessment as the resident utilized a mobility aid, and was at a specified level of risk for falls;

- Resident #021 was admitted on a particular date. Documentation identified that a PT referral was sent; however, RN #106 confirmed that there was no copy of the referral on file, nor was there indication that the resident had an initial assessment from PT services on or shortly after their admission. RN #106 identified that another PT referral to NPH should have been sent, with a copy of the completed referral kept on the resident’s chart for reference; and

- Resident #038 was admitted on a particular date. A PT referral was identified in the documentation to have been sent to NPH; however, there was no copy of the referral on file, nor was there indication that the resident had an initial assessment form PT services on or shortly after the admission. RN #106 identified that the resident would have benefited from assessment due to them being at a specific level of risk for falls, and utilizing a specific device for mobility. RN #106 indicated they would have expected that another PT referral was sent, if after the six week post admission care conference there was no documentation that an initial PT assessment was part of the resident’s health record.

In follow up to the review, RN #106 confirmed to the Inspector that all nine residents did not have a current physiotherapy assessment/reassessment. Additionally, RN #106 verified that with no referral being sent to NPH to alert the program staff and help establish a baseline assessment of each resident’s current physiotherapy needs, collaboration in the assessment of the resident with respect to physiotherapy care did not occur, and should have. [s. 6. (4) (a)]

3. 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.

During inspection #2018_703625_0007, compliance order #001 was issued to the home to address the licensee's failure to comply with s. 6 (7) of the Long Term Care Home's Act, 2007. The CO ordered the home to:

Ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

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

The compliance due date of this order was July 2, 2018.

While the licensee complied with section a, b, and d of the CO, additional non-compliance with the requirements of section c of the CO, and s. 6 (7) of the Long Term Care Home's Act, 2007 continued.

A Critical Incident (CI) report was submitted to the Director for an incident of resident to resident physical abuse. The CIS identified that resident #003 performed an action towards resident #008 resulting in injury.

During a resident observation, Inspector #679 observed a specific intervention device for resident #003 in the off position.

Inspector #679 reviewed resident #003's care plan, which identified that resident #003 exhibited specific behaviours. The care plan directed staff to implement specific interventions, and ensure that the device was on at all times.

Together, Inspector #679 and PSW #115 observed resident #003's room and identified that the switch to the device was in the off position. In an interview with PSW #115 they identified that resident #003's device was to be on at all times as per the care plan.

In an interview with RPN #104 they confirmed that the resident #003's device was to be on at all times as per the resident’s plan of care.

Inspector #679 and the DOC reviewed the electronic care plan which identified that the device was to be on at all times. The DOC identified that it was the expectation that care was provided to the resident as specified in the plan. [s. 6. (7)]

4. During an interview with Physiotherapy Assistants (PTA’s) #122 and #123, they reported to Inspector #621 that part of their responsibilities involved providing therapy services to residents who were active clients in the Nova Peak Physiotherapy Program; a contract physiotherapy service with the home. PTA #123 identified that both they and PTA #122 utilized and maintained treatment binders which contained the most current Physical Therapy care plan for each resident active in the program, and a monthly therapy log where PTA’s documented all physical therapy services and their specific treatment times, consistent with the plan of care. PTA’s #123 an #122 also identified that they provided therapy services for residents during weekdays, from Monday to Friday.

On review of resident #013’s Physical Therapy care plan, the Inspector identified specific physiotherapy interventions to be provided to this resident a specific number of times per week.

On review of resident #013’s Physiotherapy service logs for a two week period, Inspector #621 found care planned therapy documented only once.

During an interview with PTA #123, they confirmed to Inspector #621 that therapy services were provided only once during the two week period, in spite of resident #013’s Physical Therapy care plan identifying specific interventions to be provided a specific number of times per week. PTA #123 identified that due to conflicting workload demands and insufficient staffing PTA services had not been provided to this resident consistent with their Physical Therapy care plan, and should have been.

During an interview with the Administrator, they confirmed with Inspector #621 that it was their expectation that physical therapy staff provided care consistent with the Physical Therapy plan of care for each resident. [s. 6. (7)]

5. On review of resident #010’s Physical Therapy care plan, the Inspector identified specific physiotherapy interventions to be provided to this resident a specific

number of times per week

On review of resident #010's Physiotherapy service logs for a two week period, Inspector #621 found no therapy service documentation for this resident.

During an interview with PTA #123, they confirmed to Inspector #621 that therapy services were not provided to resident #010 at any time in a specific month, in spite of resident #010's Physical Therapy care plan identifying specific interventions to be provided a specific number of times per week. PTA #123 identified that due to conflicting workload demands and insufficient staffing PTA services had not been provided to this resident consistent with their Physical Therapy care plan, and should have been.

During an interview with the Administrator, they confirmed with Inspector #621 that it was their expectation that physical therapy staff provided care consistent with the Physical Therapy plan of care for each resident. [s. 6. (7)]

6. On review of resident #007's Physical Therapy care plan, the Inspector identified specific physiotherapy interventions to be provided to this resident a specific number of times per week

On review of resident #007's Physiotherapy service logs for a two week period, Inspector #621 found no therapy service documentation for this resident.

During an interview with PTA #123, they confirmed to Inspector #621 that there was no documentation on resident #007's therapy service record for a specific month due to conflicting workload demands and insufficient staffing; that the Physical Therapy care plan dated a particular date was the most current for resident #007, identifying specific therapy interventions to be provided a number of times per week; and that PTA services had not been provided to this resident consistent with their Physical Therapy care plan, and should have been.

During an interview with the Administrator, they confirmed with Inspector #621 that it was their expectation that physical therapy staff provided care consistent with the Physical Therapy plan of care for each resident. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)The following order(s) have been amended:CO# 001,004

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

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.

During inspection #2018_703625_0007, CO #002 was issued to the home to address the licensee's failure to comply with r. 31. (3) of the Ontario Regulation 79/10. The CO ordered the home 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 was specifically ordered to:
(a) Review, revise and implement the home's staffing plan to ensure that assessed resident care and safety needs were 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 was missed was 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.

The compliance due date of this order was July 15, 2018.

The licensee failed to complete parts a, b, c, d, e and f of the order.

(A) With respect to part (a) of the order, the licensee was required to review, revise and implement the home's staffing plan to ensure that assessed resident care and safety needs were met.

Inspector #625 reviewed a document titled Nursing Shortage Hours which identified that the home had worked with staff shortages in the nursing department daily from July 15 to 24, 2018. The document also identified that ADOC #111 had worked the night shifts on July 16 and 17, 2018, and the Administrator and DOC had worked on July 21 and 22, 2018. The document also identified that the home was short 48 PSW hours on July 21, 2018, and 40 PSW hours on July 22, 2018, resulting in the Administrator, DOC and Activation staff being “pulled” to assist with resident care.

The Inspector also reviewed the home’s Nursing - Staffing Contingency Plan – Rainycrest, reviewed July 10, 2018, which identified that:
- when working two, three or four PSWs short, staff were to offer bed baths in the interim and make up any missed baths the next shift;
- when working four PSWs short, the RN was to contact Activation Staff to review or cancel programs and provide assistance with snacks/feeding, kitchen and housekeeping to assist with portering and snack cart distribution, and Support Workers were to be called in to assist.
- when working five or more PSWs short, the RN was to contact all available staff and “ALL HANDS ON DECK”. Activation was to cancel programs, help with snack cart distribution, answer call bells, porter and other duties as assigned by the RN. Managers and administrative staff were to assist as available and volunteer groups were to be contacted for assistance as necessary.
- when working two or more RPNs short, or one or more RNs short, the ADOC and/or DOC were to be notified to provide support and assistance.

Inspector #625 reviewed an email from ADOC #111 that identified the ADOC had worked:
- July 15 and 16, 2018, from 1900 hours to 0700 hours as a charge RN;
- July 18, 2018, from 1700 hours to 1900 hours supporting a new RN in the building;
- July 21, 2018, from 1430 hours to 2230 hours replacing an RPN on the West Wing; and
- July 23, 2018, from 1830 hours to 2230 hours replacing an RPN on the Special Care Unit (SCU).

Inspector #625 also reviewed an email from the DOC that identified they had worked replacing an RN for three hours on July 17, 2018.

During an interview with Inspector #679, PSW #116 stated that staffing levels were very bad on the weekend, that the home had identified they would be short days shifts by seven PSWs on July 21, 2018, and six PSWs on July 22, 2018.

During an interview with Inspector #625, PSW #126 stated they had worked July 21 and 22, 2018, when the home was short staffed, and the West Wing worked with three PSWs instead of six on July 21, and four PSWs instead of six on July 22. The PSW identified that they did not know if all baths had been completed, that the DOC assisted with mechanical lifts and the RD attended both mornings and completed the nourishment pass.

During an interview with PSW #127, they stated they had worked July 21 and 22, 2018, when the home had been short staffed. The PSW identified that a Dietary Aide, who “knows nothing about the residents” assisted on the unit from 1500 hours to 2030 hours by answering call bells, "running around" and passing messages, and completing the nourishment pass over 2.5 hours. The PSW identified that residents had to wait for help with the washroom, and the PSW had waited for 20 minutes for a second staff member to assist them with a resident in the washroom.

During an interview with PSW #128, they stated they had worked on July 21 and 22, 2018, when the unit worked short. The PSW stated that on July 21, 2018, the unit worked with four PSWs during the day shift and one PSW from 0700 hours to 0900 hours who stayed to help after their night shift; and on July 22, 2018, the unit worked with four PSWs [instead of eight PSWs each day shift]. The PSW identified that staff from other departments assisted on the unit:
- Support Worker #129 answered call bells, portered residents and assisted with the sit to stand lift transfers [although they had not received training];
- the DOC answered call bells;
- the Administrator assisted to support the unit;
- Restorative employee #130 portered residents;
- Activation employee #131 distributed the fluid cart and made beds;
- the Registered Dietitian portered residents; and
- The Receptionist portered residents to the dining room.

During an interview with PSW #132, they stated they had worked on July 21, 2018,

when the unit was short staffed as there were four PSWs working [instead of 8]. The PSW stated it was "so bad I thought of quitting". The PSW stated the DOC provided the direction to give residents bed baths, they asked those residents that could answer if they wanted a bed bath or no bath due to the short staffing, and most chose a bed bath. The PSW stated those residents who could not respond were provided with bed baths. The PSW also stated that they had performed transfers with Support Worker #129 on July 21, 2018, as they did not know the Support Worker had not been trained to assist with resident transfers.

During an interview with RN #133, they stated they had worked the weekend of July 21 and 22, 2018. The RN stated that treatments did not get completed on July 22, that new RN #134 worked that weekend and had not known what to do as they had not had an orientation to working as an RN prior to working that weekend. The RN also stated they had assessed a few residents with wounds but were not able to complete the care plans until the following day, as they also helped on the floor which resulted in some of the RN responsibilities not being completed.

During an interview with the Administrator, they stated that they, the DOC, ADOC #111 and the Receptionist had attended the home on July 21 and 22, 2018, to assist the staff. The Administrator stated that the PSWs were supported as follows:
- the Administrator, the DOC, the Receptionist and Restorative employee #130 portered residents, fed residents, provided beverages to residents and wiped resident's faces and hands;
- the DOC also participated in resident care and answered call bells;
- Housekeepers were assigned to make beds as they cleaned resident rooms;
- the RD completed the nutrition passes and helped in the dining room with feeding;
- Kitchen staff helped porter residents into the dining room and applied clothing protectors; and
- Activation staff assisted with the nutrition pass, and portered and fed residents in the dining room.

In summary, based on staff interviews and record reviews, the home did not implement a nursing staffing plan that ensured the residents' care and safety needs had been met on July 21 and 22, 2018. The home was not able to sustain a nursing staffing plan that consisted of an adequate amount of nursing staff to ensure that assessed resident care and safety needs could be met and, as a result, were required to follow the home's nursing staffing contingency plan. The home's nursing staffing contingency plan failed to meet the residents' care and safety

needs with respect to the completion of skin and wound treatments, the provision of baths as per the residents' preferred type and frequency of bathing and the safe transferring of residents.

With respect to part (a) of the order, the licensee failed to review, revise and implement the home's staffing plan to ensure that assessed resident care and safety needs were met.

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

Inspector #625 reviewed documents provided by Administrative Assistant #135 which identified:
- the full staffing complement in the home consisted of four full time float RNs, two full time Unit Coordinator RNs, four part time RNs; 12 full time RPNs, seven part time RPNs; 39 full time PSWs and 11 part time PSWs.
- on May 25, 2018, the date the licensee was served CO #002, the home had one full time Unit Coordinator RN vacancy and two part time RN vacancies; three part time RPN vacancies; six full time and four part time PSW vacancies.
- on July 15, 2018, the date CO #002 was due, the home had one part time RN vacancy; two full time and four part time RPN vacancies; five full time and four part time PSW vacancies.
- during the inspection, one full time PSW provided notice to change their status from full time to casual effective September 1, 2018, and two full time PSWs provided notice that they were ending their employment with Rainycrest.

On July 26, 2018, the Inspector reviewed the home's staffing schedule which reflected one part time RN; two full time RPNs, four part time RPNs; five full time PSWs and four part time PSW vacancies.

During an interview with Receptionist #136, they stated that the home's staffing levels were not where they needed to be to staff the home, that the home required more registered nursing staff and PSWs, and that the home was anticipated to be short seven PSWs over the weekend of July 21 and 22, 2018. Receptionist #136 identified that there were no staff left to bring in to work and they were very concerned about the staffing over the weekend.

During an interview with Administrative Assistant #135, they stated that the home

had one part time RN vacancy, two full time RPN vacancies and two part time RPN vacancies, five full time PSW vacancies and four part time PSW vacancies.

During an interview with the Administrator, they stated that the home had one full time RN vacancy, two full time RPN vacancies, two part time RPN vacancies and eight full time PSW vacancies. The Administrator stated that the home had recruited and retained some staff, but at the same time they had lost other staff.

With respect to part (b) of the order, from May 25, 2018, (the date the home was served CO #002) to July 26, 2018, (the last day of the current inspection) the licensee failed to recruit and retain staff to fill staffing vacancies.

The Inspector also reviewed a document titled "Nursing Shortage Hours" compiled by Receptionist #136, who completed short term staffing replacement. The document identified that, from July 15 to 24, 2018, the home was short 71 registered nursing staff hours and 205 PSW hours (with a daily average of 7.1 registered nursing staff hours and 20.5 PSW hours per day, and a daily maximum of 20.75 registered nursing staff hours and 48 PSW hours short). The total staff hours short was 276 hours, for a daily average of 27.6 hours.

The Inspector compared the staffing shortages with those identified in inspection report #2018_703625_0007, from which CO #002 was issued. From April 15 to 25, 2018, the report identified that the home had been short 22.75 registered nursing staff hours and 308 PSW hours (with a daily average of 2.1 registered nursing staff hours and 28 PSW hours per day). The total staff hours short was 330.75, for a daily average of 30 hours.

During an interview with the home's Administrator, they stated that they did not have a document that they referred to when looking at the nursing shortage hours experienced, but that the home had worked short staffed. After reviewing the Nursing Shortage Hours spreadsheet, they acknowledged that the home was still operating with shortages in nursing staff hours.

With respect to part (b) of the order, the licensee had failed to reduce the amount of nursing shortage hours by an appreciable amount.

(C) With respect to part (c) of the order, the licensee was required to develop and implement daily audits to ensure that, when working short staffed, all resident care that was missed was made up in a timely manner, as appropriate. Care that was to

be audited included, but was 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.

(i) Skin and Wound Care
Inspector reviewed a “Resident Treatment Audit” for the East Wing for the week of July 16 to 22, 2018, that identified residents #023, #028, #029, #031 and #032 did not have a total of ten skin and wound care treatments completed on July 21, 2018, and residents #027 and #030 did not have a total of five skin and wound care treatments completed on July 22, 2018. Of the 15 treatments scheduled and not completed, 12 were listed as daily treatments, one was to be completed on Saturdays, and two were to be completed on Saturdays and as needed.

Inspector reviewed an “ONA/Long-Term Care Professional Responsibility Workload (PRW) Report Form” that identified RN #113 had worked on July 21, 2018, when the home was short staffed by multiple registered nursing staff. The report form identified that the dressings on the East Wing had not been completed and a factor identified as believed to contribute to the workload issues was “inadequate staff to provide safe care”. Recommendations required to address and prevent similar occurrences were “float/casual pool” and “replace sick calls/LOAs, etc.”

A review of an “ONA/Long-Term Care Professional Responsibility Workload (PRW) Report Form” identified RN #137 had worked on July 18, 2018, when the home was short staffed by multiple registered nursing staff. The report form identified that the RN had been unable to assess three residents for skin related issues. The document identified the following recommendations to address and prevent similar occurrences: adjust RN staffing, float/casual pool, adjust support staffing, review nurse/resident ratio and replace sick calls/LOAs, etc.

A review of Nursing Shortage Hours identified that the home was short 48 PSW hours on July 21, 2018, and 40 PSW hours on July 22, 2018, resulting in the Administrator, DOC and Activation staff being “pulled” to assist with resident care.

During an interview with RN #133, the stated they had worked from 0700 hours to 1900 hours on Saturday July 21 and Sunday July 22, 2018, when the home was working short staffed. The RN identified that skin and wound treatments did not get done on July 22. The RN identified that there were a few residents with wounds

which they assessed but couldn't finish care plans until July 23. The RN identified that managers, the DOC, and staff from other departments helped out due to the staffing shortages. The RN stated they also helped provide resident care on the floor which resulted in some RN tasks not being completed, including skin and wound care treatments.

During an interview with ADOC #138, they stated that skin and wound care audits were completed by Unit Coordinators (UCs) Monday to Friday and that the UCs would check to see if weekend documentation, treatments and assessments were completed on Mondays. The ADOC identified that the audits completed were not daily audits, but were audits that checked each day’s skin and wound care treatments. The ADOC indicated that staff would catch up on the audit after the weekend and acknowledged that ten treatments were not completed on Saturday July 21, 2018, and five were not completed on Sunday July 22, 2018, as indicated on the Resident Treatment Audit sheet. The ADOC identified that the home had experienced significant staffing shortages on the weekend that may have contributed to the missed skin and wound care interventions.

During an interview with ADOC #111, they stated that Resident Treatment Audits were completed by the UC on Mondays, that no one completed the audits on Saturdays or Sundays, and that they had not been completed in a timely fashion to correct items as appropriate.

With respect to part (c) of the order, regarding skin and wound care treatments and assessments, the licensee failed to develop and implement daily audits to ensure that, when working short staffed, all resident care that was missed was made up in a timely manner, as appropriate including the completion of skin and wound care treatments and assessments.

(ii) Provision of Beverages and Snacks
Inspector #625 reviewed the “Rainycrest Focus Audit on Resident Nourishment” which identified an auditor was to audit the nourishment list on the snack cart to ensure nourishment/snacks had been offered to all residents and documentation had been completed.

Inspector #625 reviewed an “ONA/Long-Term Care Professional Responsibility Workload (PRW) Report Form” which identified RN #137 had worked on July 18, 2018, when the home was short staffed by multiple registered nursing staff. The report form identified that the RN had been unable to complete the East Wing,

West Wing and Special Care Unit (SCU) audits for the evening nourishment pass. The document identified the following recommendations to address and prevent similar occurrences: adjust RN staffing, float/casual pool, adjust support staffing, review nurse/resident ratio and replace sick calls/LOAs, etc.

On July 25, 2018, during an interview with ADOC #111, they stated that there had been no documentation on the nourishment record for the July 21, 2018, morning beverage pass, and no documentation for the July 22, 2018, afternoon beverage pass on the Special Care Unit (SCU). They also stated that no fluid amounts had been listed on the nourishment record on July 22, 2018, for approximately 60 residents who resided on the West Wing.

With respect to part (c) of the order, regarding the provision of beverages and snacks, the licensee failed to implement daily audits to ensure that, when working short staffed, all resident care that was missed was made up in a timely manner, as appropriate including the completion of the provision of beverages and snacks.

(iii) Provision of Preferred Bathing Type and Frequency
Inspector #625 reviewed an "ONA/Long-Term Care Professional Responsibility Workload (PRW) Report Form" which identified that RN #137 had worked on July 18, 2018, when the home was short staffed by multiple registered nursing staff. The report form identified that the RN had been unable to complete the East Wing, West Wing and Special Care Unit (SCU) audits for the baths to be completed on the evening shift.

Inspector #625 reviewed a Bath Audit Tool for the East Wing for July 21, 2018, that identified five residents who had been provided bed baths which was not their indicated bathing preference, including residents #023, #033, #034; and for July 22, 2018, that identified nine residents had been provided bed baths which was not their indicated bathing preference.

A review of the East Wing's bathing schedules identified that resident #023 had a bath scheduled on specified days; resident #033 had a bath scheduled on specified days; resident #034 had a bath scheduled for specified days.

During a specified shift, four full days after residents #023, #033 and #034 were provided with bed baths instead of their preferred bathing type due to staffing shortages, Inspector #625 reviewed PSW Flow Sheets which identified that:
- resident #023 was provided with a bed bath on a specific day, and a tub bath on

their next scheduled bath date;
- resident #33 was provide with a bed bath on a specific day, and had not yet received another bath;
- resident #034 had been provided with a bed bath a specific day, and had not yet received another bath.

A review of residents #023, #033 and #034's Gold Care progress notes did not identify any documentation related to the bed baths provided on the specific day, or the provision of any type baths to the residents up to the end of specified shift on a particular date.

During an interview with PSW #127, they stated that they had worked over the weekend on July 21 and 22, 2018, when the home had worked with staffing shortages, and that all baths had not been completed on the specific shifts.

During an interview with PSW #128, they stated that they had worked over the weekend of July 21 and 22, 2018, when the home had worked with staffing shortages. The PSW stated that all except for two residents had bed baths as per direction from the DOC.

During an interview with PSW #132, they stated that they had worked on Saturday July 21, 2018, when the home had worked short staffed, when they provided bed baths to residents as per the direction of the DOC. The PSW stated they offered the residents a bed bath instead of not providing the residents with any bath, and most residents chose a bed bath while other who could not respond were given bed baths. They confirmed that residents #023, #033 and #034 had been provided with bed baths on a particular day, and they had not been provided with baths to make up the bed baths [greater than 96 hours after their preferred type of bath had been missed].

During an interview with ADOC #138 during the a specific shift on July 25, 2018, they acknowledged that residents #023, #033 and #034 had been recorded as receiving bed baths on July 21, 2018, but their PSW Flow Sheets and GoldCare progress notes did not reflect that they had subsequently been provided with the bathing choice of their preference to make up for their bed baths. The ADOC acknowledged that residents were given bed baths instead of their preferred bath type over the weekend of July 21 and 22, 2018, because of short staffing over that weekend and that it would be appropriate for the home to make up the bath of preference for the residents.

Inspector #625 reviewed a Bath Audit Tool for the SCU and West Wing and identified that resident #039 had not been provided with a bath on July 21, 2018, and residents #010, #040 and #044 had been provided with bed baths on July 21, 2018. The Bath Audit Tool did not identify any staff involved in the absence of bathing or provision of alternative bathing methods, and did not include the actions taken and the outcome of the identified bathing deviations to address those baths.

During an interview with ADOC #111 they stated that they followed up with staff regarding missed baths and baths which were not given in accordance with residents' preferences. They stated that, on July 21, 2018, resident #039's condition had deteriorated as per a discussion the ADOC had with PSW #107 and the resident was not given a bath for that reason. When the Inspector identified that PSW #107 had not worked on July 21, 2018, the ADOC stated that PSW #107 was the PSW they would ask in general. They also stated that they did not know why resident #040 was provided with a bed bath on July 21, 2018, that resident #010's condition had also deteriorated and that was why they had received a bed bath on July 21, 2018, and that resident #041's condition had declined so they were given a bed bath on July 21, 2018. The ADOC acknowledged that the outcome of the deviations from the bathing preferences was not listed on the Bath Audit Tool although a baths had not been provided to residents, and baths that had been provided were not provided in accordance with the residents' preferred bathing methods.

During an interview with the Administrator on July 26, 2018, they stated that the bed baths that had been provided to residents over the weekend due to staffing shortages had all been made up, as they had been informed on the morning on July 25, 2018, by ADOCs #138 and #111. The Administrator stated they were told, during the July 25, 2018, morning meeting, that the residents had been offered and provided their preferred bathing type as of that time to make up for the weekend bed baths [although they had not been].

With respect to part (c) of the order, regarding the bathing of residents as per their preferred type and frequency of bathing detailed in their plans of care, the licensee failed to develop and implement daily audits to ensure that, when working short staffed, all resident care that was missed was made up in a timely manner, as appropriate including the completion of bathing.

(D) With respect to part (d) of the order, the licensee was required to maintain

records of daily audits and the actions taken to rectify identified deficiencies to ensure that, when working short staffed, all resident care (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, etc.) that was missed was made up in a timely manner, as appropriate. The records were to 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.

Inspector #625 reviewed the home's Resident Treatment Audit, Resident Nourishment Audit and Bath Audit Tool, completed from July 15 to 25, 2018. The audits did not reflect that they had been completed daily as some were completed by the same staff member for seven days of a week, although the staff did not work each of the days listed. The audits did not contain the names of staff involved in the deviations from expected practice, the actions taken to address the deviations, or the outcome of the corrective action to address the deviations, for each of the incidents identified.

During this inspection in an interview with ADOC #138, they acknowledged that Resident Treatment Audits were completed Mondays to Fridays by the Unit Coordinators (UC), that the UCs checked on Mondays to determine if assessments, treatments and documentation had been completed over the weekend. The ADOC identified that the audit was not being completed as a daily audit, as staff were checking to determine if the treatments had been completed for each date, but were not doing so daily as they would catch up after a weekend.

During an interview with ADOC #111, they stated that Resident Treatment Audits were completed by the UC on Mondays, that no one completed the audits on Saturdays or Sundays, and that they had not been completed in a timely fashion to correct items as appropriate. After reviewing the Resident Treatment Audit, the ADOC indicated that they did not know why a treatment had not been completed for resident #047 on Sunday July 15, 2018. With respect to the Bath Audit Tool, they stated that they had followed up with staff regarding missed baths and baths not given in accordance with residents' preferences. The ADOC acknowledged that the outcome of the deviations from the bathing preferences was not listed on the Bath Audit Tool despite baths not being provided to residents in accordance with the residents' preferred bathing methods.

During an interview with the Administrator, they indicated that the home had not

been able to ensure that care that had been missed was made up in a timely manner, as appropriate, as treatments that had been missed over the weekends could, unfortunately, not be made up as some were daily treatments.

With respect to part (d) of the order, the licensee failed to ensure that the records included the staff involved in the events, any actions taken to address the deficiencies and the outcome of the deviance from the expected practice.

(E) With respect to part (e) of the order, the licensee was ordered to develop and implement routine monitoring processes for the toileting of residents and the bedtime and rest routines of residents.

(i) Toileting of Residents
Inspector reviewed the grounds used to support CO #002 from inspection #2018_703625_0007, which included the interviews with PSWs who had stated that, when the home was short staffed, residents who had been up prior to supper, sitting in the lounge, had to wait until the staff put them to bed to be toileted; residents who required toileting before supper were not toileted if the home was short staffed; and 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.

During an interview with ADOC #138, they stated that the home's management had discussed the order with respect to toileting residents and had determined that the home did not have any residents on a toileting plan. The ADOC stated that the home's interpretation of a toileting plan did not encompass any resident currently in the home. The ADOC identified that prompted voiding was performed for residents; however, it was not listed as such in the care plan. The ADOC identified that no monitoring or auditing of the toileting of residents had occurred in the home.

During an interview with ADOC #111, they stated that there were no residents in the home who were on toileting routines other than the general times residents were toileted. The ADOC stated that a toileting routine referred to specific times a resident was toileted. They stated that, if a resident's plan of care identified they were to be toileted after meals and before bed, that would be specific to that resident so it would be a routine. They identified that no residents on the SCU or West Wing were on prompted voiding routines to promote continence, but that after meals, residents were generally toileted before being put back to bed. The ADOC identified that the home followed a traditional toileting process that was provided

when PSWs toileted residents after lunch and after nourishment, and when they completed their rounds; that PSWs checked almost every resident every two hours and would take those who required it to be toileted to manage continence. The ADOC acknowledged that the home had not implemented a routine monitoring process for the toileting of residents.

During an interview with the home's Administrator, they stated that the home had not completed any audits for the toileting of residents as they had thought that the order only pertained to one resident who had a scheduled toileting plan and not to the other residents in the home who were to be toileted before and after meals.

Inspector #625 reviewed the home's policies related to the toileting of residents which included the:
- "Continence Care and Bowel Management Program Direct Care Provider Procedure", printed January 3, 2013, that identified staff were to offer trips to the washroom for residents who were unable to toilet independently;
- "Bladder Retraining Procedure", printed January 3, 2013, that defined bladder retraining programs as most appropriate for residents with urgent urinary incontinence; and most effective for residents who were alert, could fully understand, communicate and were able to follow instructions. The procedure indicated that bladder retraining used scheduled voiding to restore normal bladder function or to improve continence.
- "Prompted Voiding Procedure", printed October 29, 2013, that identified prompted voiding as a behavioual intervention used to treat residents with stress, urge and functional urinary incontinence; and was most successful for residents with physical and/or cognitive deficits who would respond to timely reminders from caregivers. This technique involved prompting an individuals to use the toilet at regular intervals to encourage the maintenance of bladder control.
- "Toileting Routine Procedure", printed October 29, 2013, that defined toileting routines as most appropriate for residents with urge urinary incontinence and noted that an individualized toileting routine could be established for residents who had the ability to be toileted as exhibited by a prompted voiding trial. Residents were to be toileted based on the individual resident's pattern at the following times: upon awakening in the morning, after breakfast, before or after lunch, before or after supper, at bedtime and during the night if the resident was awake.

With respect to part (e) of the order, the licensee failed to develop and implement routine monitoring processes for the toileting of residents.

(ii) Bedtime and Rest Routines
The Inspector reviewed the grounds used to support CO #002 from inspection #2018_703625_0007, which included a PSW interview that identified, when the home had worked short staffed on a particular date, two residents could not be transferred to bed during the evening shift but had to wait until the night shift staff arrived to assist them to bed.

During an interview with ADOC #138, they stated that they had not monitored the sleep and rest routines of residents in the home, nor had they created a monitoring process to do so.

During an interview with ADOC #111, when asked about the monitoring that the home had completed with respect to sleep and rest routines, they stated that residents' sleep and rest routines could be found in their care plans and that the home had no complaints that residents were not put to bed on time.

With respect to part (e) of the order, the licensee failed to develop and implement routine monitoring processes for the bedtime and rest routines of residents.

(F) With respect to part (f) of the order, the licensee was ordered to maintain records of the monitoring processes and the actions taken to rectify identified deficiencies with respect to the toileting of residents and the bedtime and rest routines of residents. The records were to 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. The licensee failed to complete any monitoring and maintain any related monitoring. See section (E) for further details. [s. 31. (3)]

Additional Required Actions:

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

(A3)The following order(s) have been amended:CO# 002

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. 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.

During inspection #2018_703625_0007, compliance order #004 was issued to the home to address the licensee's failure to comply with r. 36. of the Ontario Regulation 79/10. The CO ordered the home to:

(a) Ensure that all staff received training in the safe and correct use of equipment, including mechanical lifts, prior to performing their responsibilities;
(b) Ensure that all staff received 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.

The compliance due date of this order was July 15, 2018.

The licensee completed part c of the order; however, the licensee failed to

completed parts a, b and d.

(i) Safe Transferring

A) On a particular date, Inspector #625 observed PSW #139 and RPN #140 transfer resident #023 using a specific transfer device. The Inspector noted that a specific accessory of the transfer device was not used during the transfer and that the resident had a specific item between their body and a component of the transfer device.

A review of resident #023's current care plan identified that staff used "a specific transfer device. Place a specific item between the residents body and a component of the transfer device". The resident's most recent physiotherapy assessment identified their transfer status as a separate transfer device.

Inspector reviewed the transfer devices "Operating and Product Care Manual" which indicated:
- The transfer device should always be handled by a trained care giver … in accordance with the instructions outlined in these Operating and Care Instructions”;

- Warning: READ BEFORE USE. Before using the transfer device you must read and fully understand these Operating and Product Care Instructions. You must be trained on the device, and any accessories as well as its functions and controls;
- The Operating and Product Care Instructions are mandatory for the safe and effective handling of the transfer device, including the safety of the resident and the caregiver”;
- "Warning: Failure to follow these instructions may result in injury …";
- Accessory used to ensure that the lower part of the resident's body stays close to the transfer device.
- Warning: An assessment must be made for each individual resident being raised by the transfer device - by a medically qualified person - as to whether the resident requires the specific accessory when using the transfer device.

During interviews with PSW #132, they stated that 90 per cent of the time they felt that resident #023 transferred unsafely using specific transfer device. PSW #132 identified that, in their opinion, most residents who used the transfer device did not transfer safely and that they used the specific transfer device with resident #023 for everything except transferring the resident at a specific time of day as the resident asked for the specific transfer device to be used. The PSW also stated that they

did not use the transfer device's accessory when transferring residents #023, #024 or #005 because the residents did not want or like the accessory being used.

During interviews with PSW #141 they stated that staff did not use the transfer device's accessory on residents, including resident #002, when using the transfer device as most residents did not want it to be used or refused to use it. The PSW stated they were aware that resident #023 had an item placed in between their body and the transfer device as a particular body part was sore and it stopped it from pressing against the transfer device. The PSW discussed that residents wanted to keep using transfer device as they still wanted to be toileted, not many residents had adaptive clothing to use for toileting with a separate transfer device and it would take additional time for staff to toilet residents using the separate transfer device. When asked for the transfer device's "Operating and Product Care Manual", the PSW stated they would ask Maintenance and returned to the Inspector with the manual stating it took a great deal of effort to find the manual.

During interviews with PSW #100, they stated that they did not normally use the accessory on the transfer device when transferring residents, including resident #002. The PSW stated they thought that, if they used the accessory, it would be considered a restraint and they would be required to sign for their application.

During an interview with resident #023, they stated that they used a specific transfer device at a particular time of day, and a separate transfer device for assistance with a specific type of care. The indicated that they did not want to use the accessory and that they did not use the accessory when using the transfer device as staff did not apply it.

During an interview with resident #024, they stated that they had told staff they did not want the accessory used when transferring with a specific device and that staff did not use the accessory.

During an interview with resident #002 they identified that staff did not use the accessory when transferring them using a transfer device.

During an interview with PSW #142, one of the three PSWs who provided lift and transfer training to staff in the home, they stated that staff were to apply the accessory when using the specified transfer device. The PSW acknowledged that residents should consider using a different type of transfer device when they did not want to use the transfer device as it was required. The PSW stated that, they

were not sure if the transfer device's manual indicated if the accessory was required or not and they did not have a copy of the manual on the unit.

During interviews with PSW #139, one of the three PSWs who provided lift and transfer training to staff in the home, they stated that they did not use the accessory when transferring residents #023, 024 or #005 and acknowledged that resident #023 used an item between their body and the transfer device at the resident’s request. The PSW acknowledged that the most recent physiotherapy assessment, identified resident #023 used a specific transfer device. They also acknowledged that the transfer device's manual identified that an assessment was required for each resident by a medically qualified person as to whether the accessory was required when using the transfer device. The PSW identified that they followed the resident's verbalized wishes on the use of the accessory, and not the directions detailed in the manual.

During an interview with RN #112, they stated that resident #023 could not use a specified device if they used a particular transfer device. The RN was not aware if there was a specific accessory to use with the transfer devices but stated that having one would be useful. The RN stated they were aware that resident #023 did not use the accessory and used an item between their body and the transfer device when transferring. The RN stated that they would not say whether it was safe for residents #023, #024 and #005 to not use the accessory on the particular transfer device but that the accessory was not used unless a resident’s feet lifted up during the transfer. The RN acknowledged that a quarterly physiotherapy assessment had identified that resident #023 used a specific transfer device, but that the staff transferred the resident using a different transfer device.

During an interview with PTA #122, they identified that resident #023 had used particular transfer device, then experienced increased pain. Following a requested transfer assessment, the physiotherapist identified the resident required a different transfer device. The physiotherapist assessment of the transfer method did not identify that the accessory was not required or that an item was to be used, but that the resident required a specific transfer device.

During an interview with PTA #123, they stated that resident #023’s physiotherapy assessment identified that a specific transfer device was required and that it should have been used for all transfers. PTA #123 indicated that pain was a factor as to why the transfer device was assessed as the appropriate transfer method. The PTA stated that the physiotherapist was asked about the use of the accessory on

the transfer device and identified that it should be used for safety.

PTA #123 also commented that resident #024's current physiotherapy assessment identified that a specific device was required for transfers but did not reference that the resident's transfer should be modified to exclude the use of the accessory. The PTA also identified that, during an assessment by the Physiotherapist they had not indicated that resident #002 did not require the accessory when using the transfer device and that the direction not to use the accessory was not identified in the Physical Therapy or ADL Assistance care plans, or the most recent physiotherapy assessment.

During an interview with Inspector #625, ADOC #111 stated that they had completed monitoring of resident transferring techniques and identified that staff had not used the accessory with the specific transfer device during one of four monitoring entries, or 25 per cent of the monitoring entries, and that they had provided reinstruction to the staff that the accessory should have been applied. The ADOC further stated that staff should not use an item between a resident's body and the transfer device, unless the manufacturer had identified it was to be used, and that if a resident experienced pain during a transfer, the resident should be assessed for another more appropriate type of transfer device that did not hurt them. The ADOC acknowledged that the transferring techniques observed by the Inspector, including the use of an item between the resident and the device, and lack of use of the accessories, were not safe transferring techniques.

During an interview with the DOC, they stated that they used the accessory when using the specific transfer device and that all staff should use the accessory when transferring residents with the device. They further stated that they had discussed the use of the accessory with the staff and had identified to the staff that the use of the accessory was not a decision that a resident could make [as staff had stated to the Inspector that it was a "resident right" to refuse the use of the accessory].

During an interview with Staff Health Nurse #143, the individual who had provided the "train-the-trainer" instruction on lifts and transfers to the home's three PSW trainers, they stated that they were not familiar with the transfer device's "Operating and Product Care Manual". With respect to the use of the accessory, they stated they had directed the DOC to refer to the home's procedure, which did not identify that the accessory was to be applied, but that not all transfer devices had the specified accessory. They then stated that the Client Mobility Assessment the home used should have addressed the use of the accessory but did not. The Staff

Health Nurse indicated that, if the operating manual identified that the specified accessory was to be used and the residents had not been assessed not to use it, as identified in the manual, it should be used, as not using it would be unsafe. They also stated that it was not a safe transferring practice for staff to use the specific transfer device on a resident who had been assessed by a Physiotherapist as requiring a different device for transfers, or to use an item positioned between a resident and the device. They stated that they hoped the staff in the home had access to the lift manuals but were not sure if they did and could not locate the manuals where they had expected they would be located.

B) On July 18, 2018, Inspector #625 observed resident #023 using a mobility aid with a specified accessory. The Inspector noted the accessory hanging in close proximity to the mobility aid's wheel.

During an interview with PTA #122, they stated that they had observed resident #023 using their mobility aid with the accessory hanging down on previous occasions, and they were concerned that the accessory would be caught in the wheel and the accessory would pull the resident from their mobility aid.

During an interview with ADOC #111, they observed resident #023 with their accessory dangling near the front wheel of the resident's mobility aid. The ADOC acknowledged that the positioning of the accessory was unsafe for the resident, who used their mobility aid independently.

During an interview with the DOC, they also observed resident #023 with the accessory dangling in front on the mobility aid's wheel. The DOC identified that the accessory was unsafely placed and could become caught in the wheel causing the resident to fall from their mobility aid.

Inspector #625 reviewed the accessories user manual which identified that:
- the [resident] must be assessed by a competent person who must be fully trained in the suitability, application and fitting of the accessory. Carers should always be trained in the use of accessory;
- the label on the accessory contains vital information to identify the accessory - if any part of the label becomes illegible, then in must be removed from service and replaced;
- the accessory should be visually inspected with regard to the label being clearly legible; and
- once the [resident] is in the chair, the accessory can be tucked away in storage

points to prevent it from trailing on the floor or snagging in the wheels.

Inspector #625 observed two accessories in the clean utility room on July 18, 19 and 24, 2018, both of which had missing labels.

During an interview with PSW #139 they acknowledged that resident #023 had been unsafely positioned due to the location of their accessory. PSW #139 identified that they had not been familiar with the user manual but, after reviewing it with the Inspector, would follow the directions provided regarding placement of the accessory and legibility of the accessory labels, removing the two accessories from the clean utility room.

During an interview with the Staff Health Nurse #143, they identified that they had provided training on safe transferring and positioning techniques in a "train the trainer" capacity to three staff from the home, including PSW #139. The Staff Health Nurse identified that they had not read the accessories user manual and were not familiar with that accessory. They stated that placement of accessory in close proximity to the wheels of a mobility device was not a safe positioning technique and the accessory should always be tucked in. Additionally, Staff Health Nurse #143 acknowledged that a visual inspection of the accessories in use should be completed to ensure that the labels [which the manufacturer identified contained vital information to identify the accessory] were in place and clearly legible. The Staff Health Nurse stated that they had provided generic training for all licensee sites and that the Inspector had identified areas and equipment that the licensee had not provided training to staff on.

C) On July 18, 2018, Inspector #625 observed PSWs #132, #139 and #144 transfer resident #025 from their wheelchair to their bed using a specific transfer device. PSW #132 had requested the assistance of PSW #139 who was a trainer in the use of mechanical lifts as it was their first time using the transfer device. During the first transfer attempt, PSW #139 selected specific points on the accessory. The transfer was not completed successfully as the accessory appeared large on the resident, it was poorly positioned and the resident's buttocks were slipping from the accessory while their arms and legs were being lifted. For the safety of the resident, the Inspector drew the PSWs' attention to the resident's buttocks, which had not completely left their mobility aid, despite the accessory and limbs being raised. The resident was immediately lowered back to their mobility aid with their buttocks now positioned at the edge of the seat which resulted in the three PSWs boosting the resident up in the mobility device manually. During the

second transfer attempt, PSW #139 instructed the staff to put the points of the accessory on differently, and the resident was transferred from their mobility device to their bed.

A review of resident #025's health care record identified the residents most recent weight, taken a number of days prior to the observed transfer.

The Inspector reviewed the sling used during the transfer and identified it was a specific sized sling which had a label listing the weight guideline as a specific number of kilograms. The sling contained a label identifying that a specific sling was the appropriate sling size for resident #025's weight.

Inspector #625 reviewed the licensee's policy titled "Minimal Lift Procedure – ORG-III-NGE-15.01" effective January 30, 2018. The policy included a section on selecting the correct accessory size which indicated that the accessory was compatible with the lift device and the resident weight, and that the accessory weight rating should be legible on the tag. The policy identified that, when using a specific transfer devices staff should refer to the manual for the specific device being used before operating the device; manuals can be found on the shared network Q-drive under 'Client Lift Manuals'".

During interviews with PSWs #139, #126, #110 and #145, they stated that PSWs did not have computer access and they were not able to access transfer device and accessory manuals on a shared drive of a computer. The PSWs stated they were not aware of how they could access the manuals.

During interviews with RPN #146 and RN #106, both accessed the shared Q drive in the Inspector's presence but were not able to locate a folder or file titled "Client Lift Manuals", and were not able to locate the manuals.

The Inspector also reviewed the transfer devices user manual that read:
- visibly inspect the accessory prior to each use to ensure the accessory is the correct type, size and design to handle lifting....that the accessories straps were correctly attached to the spreader bar; and that the accessory was tested with the resident in it at a few inches over bed or chair prior to actual lifting;
- read the Accessory Guide, which is separate from this manual. Most accidents occur from wrong accessory size or type. Make certain you understand how to select, attach, inspect and test accessories;
- ensure accessories are sized appropriately and attached appropriately to the

resident and lift. Failure to follow these instructions could result in serious injury.
- before placing the transfer device in service, require all personnel who will work with the lift to read the User's Manual;
- Ensure caregivers are trained and have read and understand the user manual and have demonstrated proper usage;
- READ SEPARATE ACCESSORY USER GUIDE FOR INFORMATION ON SELECTING, ATTACHING AND USING TRANSFER DEVICES WITH ACCESSORIES; and
- NOTE: Lift resident 1-2 inches over bed or chair, stop and then check that all points are secure, the accessory is holding the resident before further lifting. WRONG ACCESSORY SIZE CAN ALLOW RESIDENT TO FALL OUT - READ ACCESSORY USER GUIDE.

The manual also contained the specific instructions on the accessory use as follows:
- to lift the resident in a seated position, use a shorter set of loops at the shoulders and a larger set of loops at the legs. This places the resident's head higher than their legs. Resident must have some upper body strength to be in seated position or risk of falling out is possible; and
- to lift in a reclined position, use a longer set of loops at the shoulders and a shorter set of loops at the legs. This will allow the resident's head to be level with their legs.

The Inspector next reviewed the accessory guide that:
- read WARNING: Read accessory manuals carefully - Failure to use appropriate accessory, attach it properly, or inspect it for wear and tear can result in serious injury"; and
- listed the use weight guidelines for a proper fit as a small red sling for 34 to 56 kgs, a medium yellow sling for 57 to 79 kgs, and a large green sling for 80 to 113 kgs.

During an interview with PSW #132, they stated that they did not know about different types of accessories and when to use them.

During an interview with PSW #128, they stated they did not compare residents' weights to listed accessory weight ranges, but would see how the accessory fit and adjust it.

During an interview with PSW #148, they stated they would try an accessory, use it

and adjust it if needed.

During an interview with PSW #149, they stated that the accessory use was based on their judgement and identified a small accessory as having an identifying colour [the small accessories used with a specific transfer device and a separate device was identified with the a specific colour].

During an interview with PSW #139, who trained the home's staff on safe transferring and positioning techniques, they stated that they didn't recall being given training on the use of different accessories in the same transfer.

During an interview with RPN #146, they stated that they assisted with transfers using mechanical lifts but did not know about different types of a specific accessory.

During an interview with RN #150, they stated that they were aware that there were different types of accessories but did not know the different types or when to use them.

During an interview with RN #106, they stated that they were not familiar with a part of the accessory, or with the colours that corresponded to the accessory.

During an interview with PSW #139, they identified that they had been provided training on a specific transfer device from PSW #147 who had instructed the PSW to use all of the same points when attaching the accessory to the transfer device but was not sure why they were to do so. The PSW stated the first transfer attempt involving resident #025 "felt totally unsafe" and that the resident's buttocks were not positioned properly in the accessory. The PSW identified that they had selected specific points of the accessory for use as those closest to the resident's body without straining the body were for sitting and that a different point of the accessory was better for laying down. The PSW didn't recall being given training on the use of different points of the accessory in the same transfer. The PSW verified that resident #025's recent weight was recorded as a specific number in July 2018 and the accessory they had used to transfer the resident was a specific size intended for use with residents whose weights were in a specified weight range. The PSW stated that resident #025's weight identified that they were to use a specific size of accessory but that a different sized accessory was the only one the home had to use with that specific transfer device.

During an interview with the DOC, they stated that PSW #147 had attended training on the transfer device with Administrative Assistant #135. The DOC identified that the training entailed bringing the device into the office, having a video conference with the vendor and watching videos on the transfer device.

During an interview with Staff Health Nurse #143, they identified that they had provided training on safe transferring and positioning techniques in a "train the trainer" capacity to three staff from the home. They stated that they had not read the transfer device's manual or the corresponding accessory guide as the device was not in service at the time of the training. The Staff Health Nurse indicated that they did not know of any training completed on the specific device and, as far as they knew, arrangements were made for the specific device training and their supervisor, the Occupational Health and Safety Coordinator #120 had asked to be notified when training was provided so they would all be on the same page. The Staff Health Nurse identified that the use of the device's accessory was determined based on the height of the resident, their comfort level and discussion with the people that do the lifting. They identified that the accessory was usually used in a particular manner and they didn't know if there was anything in writing that said what points of the accessory to use. They identified that staff should use the accessory that fits the weight of the resident, that a incorrect fitting sling on a person could cause injury and discomfort and, they hoped, with the accessory used in a particular manner, that a larger accessory for a smaller person would not result in the resident falling out of the accessory.

(ii) Training

In respect to parts "a" and "b" of the CO, the licensee was to ensure that all staff received training in the safe and correct use of equipment, including mechanical lifts, prior to performing their responsibilities; and, ensure that all staff received retraining annually in the safe and correct use of equipment, including mechanical lifts.

During the inspection, Inspector #625 observed the home's staff use a transfer device's accessory unsafely, a specific transfer device unsafely, and use unsafe transfer techniques. Refer to section (i) of this finding for further details.

A) During interviews with the home's staff regarding the training they had been provided with respect to the mechanical lifts and slings in use, Inspector #625 discovered:

- RN #134 had training on one transfer device but was not sure if it was the regular transfer device or a different transfer device;
- PSWs #126 and #110 had not been trained on a specific transfer device;
- RN #106 had not been trained on a specific transfer device, but had participated in a transfer using the device; and,
- multiple staff, including PSWs, RPNs and RNs had not been trained on the correct sizing and types of accessories in use.

During interviews with the home's staff, it was identified that the home had acquired and put into service a new transfer device.

A review of Education Attendance Sheets for the specific transfer devices dated in May and June 2018, identified 26 staff listed on the training sheets as having attended the training.

A review of the Surge Learning training list provided by the home identified that 92 staff had attended the home's Minimal Lift training, which did not include training on the new transfer device.

The documentation provided to the Inspector did not identify that 66 out of the 92 staff, or 72 per cent of the staff, had received training on the new transfer device.

During an interview with the DOC, they stated that not all of the home's staff had been trained on use of the transfer device.

B) Inspector #625 reviewed the licensee's policy titled "Minimal Lift Procedure – ORG-III-NGE-15.01" effective January 30, 2018, which identified that, as the first step to using transfer devices that staff were to "refer to the manual for the specific transfer devices being used before operating the device; manuals can be found on the shared network Q-drive under 'Client Lift Manuals'".

During interviews with PSWs #139, #126, #110 and #145, they stated that PSWs did not have computer access and they were not able to access transfer device and accessory manuals if they were stored on a shared drive of a computer. The PSWs stated they were not aware of how they could access the manuals.

During interviews with RPN #146 and RN #106, both accessed the shared Q drive in the Inspector's presence but were not able to locate a folder or file titled "Client Lift Manuals", and were not able to locate the manuals.

During an interview with PSW #141, they offered to find a copy of a specific devices "Product Care Instructions manual" for the Inspector. The PSW left the unit and, when they returned, they stated that they had to ask Maintenance for a copy and that it “took a great deal of effort to find the manual”.

During an interview with the Staff Health Nurse #143, the employee who had provided the home’s trainers with "train-the-trainer" education on safe transferring and positioning techniques, they stated that they did not know how staff would access the transfer device and accessory manuals for the equipment in use in the home. They checked one electronic location where they believed the manuals may have been uploaded to provide staff access to them and identified that they were not present. The Staff Health Nurse identified that they had not read and were not familiar with specific transfer device's operating and product care instructions manuals. The Staff Health Nurse identified that the training they had provided to the trainers was generic and done for multiple facilities of the licensee. They also stated that there had to be more to the training as there were areas and equipment that they had not trained on.

In conclusion, with respect to parts (a) and (b) of the order, the licensee failed to (a) ensure that all staff receive training in the safe and correct use of equipment, including transfer devices, prior to performing their responsibilities; and (b) ensure that all staff received retraining annually in the same and correct use of equipment, including mechanical lifts. The licensee did not provide training that addressed the specific equipment in use in the home to ensure that it was safely and correctly used, nor did the and the licensee train all staff on a specific device before putting it into use and before the untrained staff used the lift.

(iii) Audit Record

With respect to part "d" of the order, the licensee was required to maintain records of a routine monitoring process that they had developed and implemented for the use of safe transferring techniques. The records were to 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.

Inspector #625 reviewed an audit sheet developed by the home titled “Focused Audit for Proper Use of Lift Equipment”. The audit sheet did not include areas for the names of residents involved or the outcome of the auditing observations.

One audit completed by ADOC #111 identified that staff had not demonstrated proper use of a sit to stand lift on a particular date, as they had failed to apply an accessory until reminded. Staff educated on the implications and expectations”.

Another audit completed by ADOC #138 identified that they had reminded staff member to a specific accessory prior to engaging the transfer device on a particular date.

Neither audit listed the names of the residents involved or the outcome of the audits, such as observing the compliance of the staff with the use of leg straps on other occasions to ensure that reinstruction had been effective.

During this inspection [which began five days after ADOC #111’s observation of staff not applying the accessories when using a transfer device], through observations and staff interviews, Inspector #625 identified that multiple staff did not apply the accessory when using the transfer device. The outcome of the reinstruction to staff to use the accessory on the particular transfer device had not been identified by the home and the staff had continued to use the device in an unsafe manner. [s. 36.]

Additional Required Actions:

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

(A3)The following order(s) have been amended:CO# 003

Issued on this 31 day of October 2018 (A3)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MICHELLE BERARDI (679) - (A3)
Inspection No. / No de l'inspection :	2018_655679_0022 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	011366-18, 011385-18, 011392-18, 011399-18, 011411-18 (A3)
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 31, 2018;(A3)
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

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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) (b)

Linked to Existing Order / Lien vers ordre existant: 2018_703625_0007, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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 LTCHA, 2007.

The licensee shall prepare, submit and implement a plan which will ensure that the care set out in the plan of care is provided to all residents as specified in their plan, specifically ensuring that:

a) Residents #007, #010, #013, and all other residents receive their physiotherapy service interventions as outlined in their plan of care.

b) Resident #003's behavioural interventions outlined in the plan of care are implemented as outlined in their plan of care.

The plan must be emailed to the attention of LTCH Inspector Michelle Berardi. The plan is due on September 4, 2018, and the order is to be complied by September 28, 2018.

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.

During inspection #2018_703625_0007, compliance order #001 was issued to the home to address the licensee's failure to comply with s. 6 (7) of the Long Term Care Home's Act, 2007. The CO ordered the home to:

Ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
The licensee shall specifically ensure that:
(a) toileting was provided to resident #002, and to all residents in the home, as per their plans of care;
(b) bathing and falls prevention interventions were provided to resident #005, and to all residents in the home, as per their plans of care;
(c) responsive behaviours interventions were 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 were completed for residents #012 and #013, and all residents in the home, as per their plans of care.

The compliance due date of this order was July 2, 2018.

While the licensee complied with section a, b, and d of the CO, additional non-compliance with the requirements of section c of the CO, and s. 6 (7) of the Long Term Care Home's Act, 2007 continued.

A Critical Incident (CI) report was submitted to the Director for an incident of resident to resident physical abuse. The CIS identified that resident #003 performed an action towards resident #008 resulting in injury.

During a resident observation, Inspector #679 observed a specific intervention device for resident #003 in the off position.

Inspector #679 reviewed resident #003's care plan, which identified that resident #003 exhibited specific behaviours. The care plan directed staff to implement specific interventions, and ensure that the device was on at all times.

Together, Inspector #679 and PSW #115 observed resident #003's room and identified that the switch to the device was in the off position. In an interview with PSW #115 they identified that resident #003's device was to be on at all times as per the care plan.

In an interview with RPN #104 they confirmed that the resident #003's device was to be on at all times as per the resident's plan of care.

Inspector #679 and the DOC reviewed the electronic care plan which identified that the device was to be on at all times. The DOC identified that it was the expectation that care was provided to the resident as specified in the plan. (679)

2. During an interview with Physiotherapy Assistants (PTA’s) #122 and #123, they reported to Inspector #621 that part of their responsibilities involved providing therapy services to residents who were active clients in the Nova Peak Physiotherapy Program; a contract physiotherapy service with the home. PTA #123 identified that both they and PTA #122 utilized and maintained treatment binders which contained the most current Physical Therapy care plan for each resident active in the program, and a monthly therapy log where PTA’s documented all physical therapy services and their specific treatment times, consistent with the plan of care. PTA’s #123 an #122 also identified that they provided therapy services for residents during weekdays, from Monday to Friday.

On review of resident #010’s Physical Therapy care plan, the Inspector identified specific physiotherapy interventions to be provided to this resident a specific number of times per week

On review of resident #010’s Physiotherapy service logs for a two week period, Inspector #621 found no therapy service documentation for this resident.

During an interview with PTA #123, they confirmed to Inspector #621 that therapy services were not provided to resident #010 at any time in a specific month, in spite of resident #010’s Physical Therapy care plan identifying specific interventions to be provided a specific number of times per week. PTA #123 identified that due to conflicting workload demands and insufficient staffing PTA services had not been provided to this resident consistent with their Physical Therapy care plan, and should have been.

During an interview with the Administrator, they confirmed with Inspector #621 that it was their expectation that physical therapy staff provided care consistent with the Physical Therapy plan of care for each resident. (621)

3. On review of resident #013’s Physical Therapy care plan, the Inspector identified specific physiotherapy interventions to be provided to this resident a specific number of times per week.

On review of resident #013’s Physiotherapy service logs for a two week period, Inspector #621 found care planned therapy documented only once.

During an interview with PTA #123, they confirmed to Inspector #621 that therapy services were provided only once during the two week period, in spite of resident #013’s Physical Therapy care plan identifying specific interventions to be provided a specific number of times per week. PTA #123 identified that due to conflicting workload demands and insufficient staffing PTA services had not been provided to this resident consistent with their Physical Therapy care plan, and should have been.

During an interview with the Administrator, they confirmed with Inspector #621 that it was their expectation that physical therapy staff provided care consistent with the Physical Therapy plan of care for each resident. (621)

4. On review of resident #007’s Physical Therapy care plan, the Inspector identified specific physiotherapy interventions to be provided to this resident a specific number of times per week

On review of resident #007’s Physiotherapy service logs for a two week period, Inspector #621 found no therapy service documentation for this resident.

During an interview with PTA #123, they confirmed to Inspector #621 that there was no documentation on resident #007’s therapy service record for a specific month due to conflicting workload demands and insufficient staffing; that the Physical Therapy care plan dated a particular date was the most current for resident #007, identifying specific therapy interventions to be provided a number of times per week; and that PTA services had not been provided to this resident consistent with their Physical Therapy care plan, and should have been.

During an interview with the Administrator, they confirmed with Inspector #621 that it

was their expectation that physical therapy staff provided care consistent with the Physical Therapy plan of care for each resident.

The severity of this issue was determined to be a level 2, minimum harm or potential for harm. The scope of this issue was a level 2, a pattern. The home had a level 4 history of ongoing non-compliance with this section of the Act that included:

• A Directors Referral (DR) and Compliance Order (CO) issued during inspection #2018_703625_0007, commencing April 17, 2018
• A DR and a CO issued during inspections #2017_624196_0016 and #2017_435621_0011, commencing on November 20, 2017, and March 31, 2017, respectively;
• A CO issued during inspections #2017_463616_0011 and #2016_463616_0026, commencing on July 17, 2017, and November 14, 2016, respectively;
• A CO issued during inspection #2016_339617_0021, commencing on May 30, 2016;
• A Voluntary Plan of Correction (VPC) issued during inspection #2017_395613_0001, commencing on January 9, 2017;
• A Written Notification (WN) issued during inspection #2016_320612_0018, commencing on June 20, 2016; (621)

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

Jan 15, 2019(A3)

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2018_703625_0007, CO #002;

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 comply with r. 31. (3) of the Ontario Regulation 79/10.

The licensee shall prepare, submit and implement a plan which will ensure that the home's 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 the Regulations. Specifically, the plan must identify the steps taken and the individuals responsible for the following:

(a) Continue with ongoing staff recruitment and retention efforts to fill staffing vacancies and reduce the amount of nursing shortage hours;
(b) 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.
(c) Review all residents in the home to ensure that their toileting plan of care is accurate to promote and manage continence.
(d) Review all residents in the home to ensure that their sleep and rest pattern plan of care accurately reflects the residents needs and preferences.
(e) Maintain records of the audits/reviews 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 corrective actions taken and the outcome.

The plan must be emailed to the attention of LTCH Inspector Michelle Berardi. The plan is due on September 4, 2018, and the order is to be complied by November 1, 2018.

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.

During inspection #2018_703625_0007, CO #002 was issued to the home to address the licensee's failure to comply with r. 31. (3) of the Ontario Regulation 79/10. The CO ordered the home 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 was specifically ordered to:
(a) Review, revise and implement the home's staffing plan to ensure that assessed resident care and safety needs were 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 was missed was 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.

The compliance due date of this order was July 15, 2018.

The licensee failed to complete parts a, b, c, d, e and f of the order.

(A) With respect to part (a) of the order, the licensee was required to review, revise and implement the home's staffing plan to ensure that assessed resident care and safety needs were met.

Inspector #625 reviewed a document titled Nursing Shortage Hours which identified that the home had worked with staff shortages in the nursing department daily from July 15 to 24, 2018. The document also identified that ADOC #111 had worked the

night shifts on July 16 and 17, 2018, and the Administrator and DOC had worked on July 21 and 22, 2018. The document also identified that the home was short 48 PSW hours on July 21, 2018, and 40 PSW hours on July 22, 2018, resulting in the Administrator, DOC and Activation staff being “pulled” to assist with resident care.

The Inspector also reviewed the home’s Nursing - Staffing Contingency Plan – Rainycrest, reviewed July 10, 2018, which identified that:
- when working two, three or four PSWs short, staff were to offer bed baths in the interim and make up any missed baths the next shift;
- when working four PSWs short, the RN was to contact Activation Staff to review or cancel programs and provide assistance with snacks/feeding, kitchen and housekeeping to assist with portering and snack cart distribution, and Support Workers were to be called in to assist.
- when working five or more PSWs short, the RN was to contact all available staff and “ALL HANDS ON DECK”. Activation was to cancel programs, help with snack cart distribution, answer call bells, porter and other duties as assigned by the RN. Managers and administrative staff were to assist as available and volunteer groups were to be contacted for assistance as necessary.
- when working two or more RPNs short, or one or more RNs short, the ADOC and/or DOC were to be notified to provide support and assistance.

Inspector #625 reviewed an email from ADOC #111 that identified the ADOC had worked:
- July 15 and 16, 2018, from 1900 hours to 0700 hours as a charge RN;
- July 18, 2018, from 1700 hours to 1900 hours supporting a new RN in the building;
- July 21, 2018, from 1430 hours to 2230 hours replacing an RPN on the West Wing; and
- July 23, 2018, from 1830 hours to 2230 hours replacing an RPN on the Special Care Unit (SCU).

Inspector #625 also reviewed an email from the DOC that identified they had worked replacing an RN for three hours on July 17, 2018.

During an interview with Inspector #679, PSW #116 stated that staffing levels were very bad on the weekend, that the home had identified they would be short days shifts by seven PSWs on July 21, 2018, and six PSWs on July 22, 2018.

During an interview with Inspector #625, PSW #126 stated they had worked July 21

and 22, 2018, when the home was short staffed, and the West Wing worked with three PSWs instead of six on July 21, and four PSWs instead of six on July 22. The PSW identified that they did not know if all baths had been completed, that the DOC assisted with mechanical lifts and the RD attended both mornings and completed the nourishment pass.

During an interview with PSW #127, they stated they had worked July 21 and 22, 2018, when the home had been short staffed. The PSW identified that a Dietary Aide, who “knows nothing about the residents” assisted on the unit from 1500 hours to 2030 hours by answering call bells, "running around" and passing messages, and completing the nourishment pass over 2.5 hours. The PSW identified that residents had to wait for help with the washroom, and the PSW had waited for 20 minutes for a second staff member to assist them with a resident in the washroom.

During an interview with PSW #128, they stated they had worked on July 21 and 22, 2018, when the unit worked short. The PSW stated that on July 21, 2018, the unit worked with four PSWs during the day shift and one PSW from 0700 hours to 0900 hours who stayed to help after their night shift; and on July 22, 2018, the unit worked with four PSWs [instead of eight PSWs each day shift]. The PSW identified that staff from other departments assisted on the unit:
- Support Worker #129 answered call bells, portered residents and assisted with the sit to stand lift transfers [although they had not received training];
- the DOC answered call bells;
- the Administrator assisted to support the unit;
- Restorative employee #130 portered residents;
- Activation employee #131 distributed the fluid cart and made beds;
- the Registered Dietitian portered residents; and
- The Receptionist portered residents to the dining room.

During an interview with PSW #132, they stated they had worked on July 21, 2018, when the unit was short staffed as there were four PSWs working [instead of 8]. The PSW stated it was “so bad I thought of quitting”. The PSW stated the DOC provided the direction to give residents bed baths, they asked those residents that could answer if they wanted a bed bath or no bath due to the short staffing, and most chose a bed bath. The PSW stated those residents who could not respond were provided with bed baths. The PSW also stated that they had performed transfers with Support Worker #129 on July 21, 2018, as they did not know the Support Worker had not been trained to assist with resident transfers.

During an interview with RN #133, they stated they had worked the weekend of July 21 and 22, 2018. The RN stated that treatments did not get completed on July 22, that new RN #134 worked that weekend and had not known what to do as they had not had an orientation to working as an RN prior to working that weekend. The RN also stated they had assessed a few residents with wounds but were not able to complete the care plans until the following day, as they also helped on the floor which resulted in some of the RN responsibilities not being completed.

During an interview with the Administrator, they stated that they, the DOC, ADOC #111 and the Receptionist had attended the home on July 21 and 22, 2018, to assist the staff. The Administrator stated that the PSWs were supported as follows:
- the Administrator, the DOC, the Receptionist and Restorative employee #130 portered residents, fed residents, provided beverages to residents and wiped resident's faces and hands;
- the DOC also participated in resident care and answered call bells;
- Housekeepers were assigned to make beds as they cleaned resident rooms;
- the RD completed the nutrition passes and helped in the dining room with feeding;
- Kitchen staff helped porter residents into the dining room and applied clothing protectors; and
- Activation staff assisted with the nutrition pass, and portered and fed residents in the dining room.

In summary, based on staff interviews and record reviews, the home did not implement a nursing staffing plan that ensured the residents' care and safety needs had been met on July 21 and 22, 2018. The home was not able to sustain a nursing staffing plan that consisted of an adequate amount of nursing staff to ensure that assessed resident care and safety needs could be met and, as a result, were required to follow the home's nursing staffing contingency plan. The home's nursing staffing contingency plan failed to meet the residents' care and safety needs with respect to the completion of skin and wound treatments, the provision of baths as per the residents' preferred type and frequency of bathing and the safe transferring of residents.

With respect to part (a) of the order, the licensee failed to review, revise and implement the home's staffing plan to ensure that assessed resident care and safety needs were met.

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

Inspector #625 reviewed documents provided by Administrative Assistant #135 which identified:
- the full staffing complement in the home consisted of four full time float RNs, two full time Unit Coordinator RNs, four part time RNs; 12 full time RPNs, seven part time RPNs; 39 full time PSWs and 11 part time PSWs.
- on May 25, 2018, the date the licensee was served CO #002, the home had one full time Unit Coordinator RN vacancy and two part time RN vacancies; three part time RPN vacancies; six full time and four part time PSW vacancies.
- on July 15, 2018, the date CO #002 was due, the home had one part time RN vacancy; two full time and four part time RPN vacancies; five full time and four part time PSW vacancies.
- during the inspection, one full time PSW provided notice to change their status from full time to casual effective September 1, 2018, and two full time PSWs provided notice that they were ending their employment with Rainycrest.

On July 26, 2018, the Inspector reviewed the home's staffing schedule which reflected one part time RN; two full time RPNs, four part time RPNs; five full time PSWs and four part time PSW vacancies.

During an interview with Receptionist #136, they stated that the home's staffing levels were not where they needed to be to staff the home, that the home required more registered nursing staff and PSWs, and that the home was anticipated to be short seven PSWs over the weekend of July 21 and 22, 2018. Receptionist #136 identified that there were no staff left to bring in to work and they were very concerned about the staffing over the weekend.

During an interview with Administrative Assistant #135, they stated that the home had one part time RN vacancy, two full time RPN vacancies and two part time RPN vacancies, five full time PSW vacancies and four part time PSW vacancies.

During an interview with the Administrator, they stated that the home had one full time RN vacancy, two full time RPN vacancies, two part time RPN vacancies and eight full time PSW vacancies. The Administrator stated that the home had recruited and retained some staff, but at the same time they had lost other staff.

With respect to part (b) of the order, from May 25, 2018, (the date the home was served CO #002) to July 26, 2018, (the last day of the current inspection) the licensee failed to recruit and retain staff to fill staffing vacancies.

The Inspector also reviewed a document titled “Nursing Shortage Hours” compiled by Receptionist #136, who completed short term staffing replacement. The document identified that, from July 15 to 24, 2018, the home was short 71 registered nursing staff hours and 205 PSW hours (with a daily average of 7.1 registered nursing staff hours and 20.5 PSW hours per day, and a daily maximum of 20.75 registered nursing staff hours and 48 PSW hours short). The total staff hours short was 276 hours, for a daily average of 27.6 hours.

The Inspector compared the staffing shortages with those identified in inspection report #2018_703625_0007, from which CO #002 was issued. From April 15 to 25, 2018, the report identified that the home had been short 22.75 registered nursing staff hours and 308 PSW hours (with a daily average of 2.1 registered nursing staff hours and 28 PSW hours per day). The total staff hours short was 330.75, for a daily average of 30 hours.

During an interview with the home’s Administrator, they stated that they did not have a document that they referred to when looking at the nursing shortage hours experienced, but that the home had worked short staffed. After reviewing the Nursing Shortage Hours spreadsheet, they acknowledged that the home was still operating with shortages in nursing staff hours.

With respect to part (b) of the order, the licensee had failed to reduce the amount of nursing shortage hours by an appreciable amount.

(C) With respect to part (c) of the order, the licensee was required to develop and implement daily audits to ensure that, when working short staffed, all resident care that was missed was made up in a timely manner, as appropriate. Care that was to be audited included, but was 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.

(i) Skin and Wound Care

Inspector reviewed a “Resident Treatment Audit” for the East Wing for the week of July 16 to 22, 2018, that identified residents #023, #028, #029, #031 and #032 did not have a total of ten skin and wound care treatments completed on July 21, 2018, and residents #027 and #030 did not have a total of five skin and wound care treatments completed on July 22, 2018. Of the 15 treatments scheduled and not completed, 12 were listed as daily treatments, one was to be completed on Saturdays, and two were to be completed on Saturdays and as needed.

Inspector reviewed an “ONA/Long-Term Care Professional Responsibility Workload (PRW) Report Form” that identified RN #113 had worked on July 21, 2018, when the home was short staffed by multiple registered nursing staff. The report form identified that the dressings on the East Wing had not been completed and a factor identified as believed to contribute to the workload issues was “inadequate staff to provide safe care”. Recommendations required to address and prevent similar occurrences were “float/casual pool” and “replace sick calls/LOAs, etc.”

A review of an “ONA/Long-Term Care Professional Responsibility Workload (PRW) Report Form” identified RN #137 had worked on July 18, 2018, when the home was short staffed by multiple registered nursing staff. The report form identified that the RN had been unable to assess three residents for skin related issues. The document identified the following recommendations to address and prevent similar occurrences: adjust RN staffing, float/casual pool, adjust support staffing, review nurse/resident ratio and replace sick calls/LOAs, etc.

A review of Nursing Shortage Hours identified that the home was short 48 PSW hours on July 21, 2018, and 40 PSW hours on July 22, 2018, resulting in the Administrator, DOC and Activation staff being “pulled” to assist with resident care.

During an interview with RN #133, the stated they had worked from 0700 hours to 1900 hours on Saturday July 21 and Sunday July 22, 2018, when the home was working short staffed. The RN identified that skin and wound treatments did not get done on July 22. The RN identified that there were a few residents with wounds which they assessed but couldn't finish care plans until July 23. The RN identified that managers, the DOC, and staff from other departments helped out due to the staffing shortages. The RN stated they also helped provide resident care on the floor which resulted in some RN tasks not being completed, including skin and wound care treatments.

During an interview with ADOC #138, they stated that skin and wound care audits were completed by Unit Coordinators (UCs) Monday to Friday and that the UCs would check to see if weekend documentation, treatments and assessments were completed on Mondays. The ADOC identified that the audits completed were not daily audits, but were audits that checked each day's skin and wound care treatments. The ADOC indicated that staff would catch up on the audit after the weekend and acknowledged that ten treatments were not completed on Saturday July 21, 2018, and five were not completed on Sunday July 22, 2018, as indicated on the Resident Treatment Audit sheet. The ADOC identified that the home had experienced significant staffing shortages on the weekend that may have contributed to the missed skin and wound care interventions.

During an interview with ADOC #111, they stated that Resident Treatment Audits were completed by the UC on Mondays, that no one completed the audits on Saturdays or Sundays, and that they had not been completed in a timely fashion to correct items as appropriate.

With respect to part (c) of the order, regarding skin and wound care treatments and assessments, the licensee failed to develop and implement daily audits to ensure that, when working short staffed, all resident care that was missed was made up in a timely manner, as appropriate including the completion of skin and wound care treatments and assessments.

(ii) Provision of Beverages and Snacks
Inspector #625 reviewed the "Rainycrest Focus Audit on Resident Nourishment" which identified an auditor was to audit the nourishment list on the snack cart to ensure nourishment/snacks had been offered to all residents and documentation had been completed.

Inspector #625 reviewed an "ONA/Long-Term Care Professional Responsibility Workload (PRW) Report Form" which identified RN #137 had worked on July 18, 2018, when the home was short staffed by multiple registered nursing staff. The report form identified that the RN had been unable to complete the East Wing, West Wing and Special Care Unit (SCU) audits for the evening nourishment pass. The document identified the following recommendations to address and prevent similar occurrences: adjust RN staffing, float/casual pool, adjust support staffing, review nurse/resident ratio and replace sick calls/LOAs, etc.

On July 25, 2018, during an interview with ADOC #111, they stated that there had been no documentation on the nourishment record for the July 21, 2018, morning beverage pass, and no documentation for the July 22, 2018, afternoon beverage pass on the Special Care Unit (SCU). They also stated that no fluid amounts had been listed on the nourishment record on July 22, 2018, for approximately 60 residents who resided on the West Wing.

With respect to part (c) of the order, regarding the provision of beverages and snacks, the licensee failed to implement daily audits to ensure that, when working short staffed, all resident care that was missed was made up in a timely manner, as appropriate including the completion of the provision of beverages and snacks.

(iii) Provision of Preferred Bathing Type and Frequency
Inspector #625 reviewed an "ONA/Long-Term Care Professional Responsibility Workload (PRW) Report Form" which identified that RN #137 had worked on July 18, 2018, when the home was short staffed by multiple registered nursing staff. The report form identified that the RN had been unable to complete the East Wing, West Wing and Special Care Unit (SCU) audits for the baths to be completed on the evening shift.

Inspector #625 reviewed a Bath Audit Tool for the East Wing for July 21, 2018, that identified five residents who had been provided bed baths which was not their indicated bathing preference, including residents #023, #033, #034; and for July 22, 2018, that identified nine residents had been provided bed baths which was not their indicated bathing preference.

A review of the East Wing's bathing schedules identified that resident #023 had a bath scheduled on specified days; resident #033 had a bath scheduled on specified days; resident #034 had a bath scheduled for specified days.

During a specified shift, four full days after residents #023, #033 and #034 were provided with bed baths instead of their preferred bathing type due to staffing shortages, Inspector #625 reviewed PSW Flow Sheets which identified that:
- resident #023 was provided with a bed bath on a specific day, and a tub bath on their next scheduled bath date;
- resident #33 was provide with a bed bath on a specific day, and had not yet received another bath;
- resident #034 had been provided with a bed bath a specific day, and had not yet

received another bath.

A review of residents #023, #033 and #034's Gold Care progress notes did not identify any documentation related to the bed baths provided on the specific day, or the provision of any type baths to the residents up to the end of specified shift on a particular date.

During an interview with PSW #127, they stated that they had worked over the weekend on July 21 and 22, 2018, when the home had worked with staffing shortages, and that all baths had not been completed on the specific shifts.

During an interview with PSW #128, they stated that they had worked over the weekend of July 21 and 22, 2018, when the home had worked with staffing shortages. The PSW stated that all except for two residents had bed baths as per direction from the DOC.

During an interview with PSW #132, they stated that they had worked on Saturday July 21, 2018, when the home had worked short staffed, when they provided bed baths to residents as per the direction of the DOC. The PSW stated they offered the residents a bed bath instead of not providing the residents with any bath, and most residents chose a bed bath while other who could not respond were given bed baths. They confirmed that residents #023, #033 and #034 had been provided with bed baths on a particular day, and they had not been provided with baths to make up the bed baths [greater than 96 hours after their preferred type of bath had been missed].

During an interview with ADOC #138 during the a specific shift on July 25, 2018, they acknowledged that residents #023, #033 and #034 had been recorded as receiving bed baths on July 21, 2018, but their PSW Flow Sheets and GoldCare progress notes did not reflect that they had subsequently been provided with the bathing choice of their preference to make up for their bed baths. The ADOC acknowledged that residents were given bed baths instead of their preferred bath type over the weekend of July 21 and 22, 2018, because of short staffing over that weekend and that it would be appropriate for the home to make up the bath of preference for the residents.

Inspector #625 reviewed a Bath Audit Tool for the SCU and West Wing and identified that resident #039 had not been provided with a bath on July 21, 2018, and residents #010, #040 and #044 had been provided with bed baths on July 21, 2018. The Bath

Audit Tool did not identify any staff involved in the absence of bathing or provision of alternative bathing methods, and did not include the actions taken and the outcome of the identified bathing deviations to address those baths.

During an interview with ADOC #111 they stated that they followed up with staff regarding missed baths and baths which were not given in accordance with residents’ preferences. They stated that, on July 21, 2018, resident #039’s condition had deteriorated as per a discussion the ADOC had with PSW #107 and the resident was not given a bath for that reason. When the Inspector identified that PSW #107 had not worked on July 21, 2018, the ADOC stated that PSW #107 was the PSW they would ask in general. They also stated that they did not know why resident #040 was provided with a bed bath on July 21, 2018, that resident #010’s condition had also deteriorated and that was why they had received a bed bath on July 21, 2018, and that resident #041’s condition had declined so they were given a bed bath on July 21, 2018. The ADOC acknowledged that the outcome of the deviations from the bathing preferences was not listed on the Bath Audit Tool although a baths had not been provided to residents, and baths that had been provided were not provided in accordance with the residents’ preferred bathing methods.

During an interview with the Administrator on July 26, 2018, they stated that the bed baths that had been provided to residents over the weekend due to staffing shortages had all been made up, as they had been informed on the morning on July 25, 2018, by ADOCs #138 and #111. The Administrator stated they were told, during the July 25, 2018, morning meeting, that the residents had been offered and provided their preferred bathing type as of that time to make up for the weekend bed baths [although they had not been].

With respect to part (c) of the order, regarding the bathing of residents as per their preferred type and frequency of bathing detailed in their plans of care, the licensee failed to develop and implement daily audits to ensure that, when working short staffed, all resident care that was missed was made up in a timely manner, as appropriate including the completion of bathing.

(D) With respect to part (d) of the order, the licensee was required to maintain records of daily audits and the actions taken to rectify identified deficiencies to ensure that, when working short staffed, all resident care (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, etc.) that was missed was made up in a timely manner, as appropriate. The records were to 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.

Inspector #625 reviewed the home's Resident Treatment Audit, Resident Nourishment Audit and Bath Audit Tool, completed from July 15 to 25, 2018. The audits did not reflect that they had been completed daily as some were completed by the same staff member for seven days of a week, although the staff did not work each of the days listed. The audits did not contain the names of staff involved in the deviations from expected practice, the actions taken to address the deviations, or the outcome of the corrective action to address the deviations, for each of the incidents identified.

During this inspection in an interview with ADOC #138, they acknowledged that Resident Treatment Audits were completed Mondays to Fridays by the Unit Coordinators (UC), that the UCs checked on Mondays to determine if assessments, treatments and documentation had been completed over the weekend. The ADOC identified that the audit was not being completed as a daily audit, as staff were checking to determine if the treatments had been completed for each date, but were not doing so daily as they would catch up after a weekend.

During an interview with ADOC #111, they stated that Resident Treatment Audits were completed by the UC on Mondays, that no one completed the audits on Saturdays or Sundays, and that they had not been completed in a timely fashion to correct items as appropriate. After reviewing the Resident Treatment Audit, the ADOC indicated that they did not know why a treatment had not been completed for resident #047 on Sunday July 15, 2018. With respect to the Bath Audit Tool, they stated that they had followed up with staff regarding missed baths and baths not given in accordance with residents' preferences. The ADOC acknowledged that the outcome of the deviations from the bathing preferences was not listed on the Bath Audit Tool despite baths not being provided to residents in accordance with the residents' preferred bathing methods.

During an interview with the Administrator, they indicated that the home had not been able to ensure that care that had been missed was made up in a timely manner, as appropriate, as treatments that had been missed over the weekends could, unfortunately, not be made up as some were daily treatments.

With respect to part (d) of the order, the licensee failed to ensure that the records included the staff involved in the events, any actions taken to address the deficiencies and the outcome of the deviance from the expected practice.

(E) With respect to part (e) of the order, the licensee was ordered to develop and implement routine monitoring processes for the toileting of residents and the bedtime and rest routines of residents.

(i) Toileting of Residents
Inspector reviewed the grounds used to support CO #002 from inspection #2018_703625_0007, which included the interviews with PSWs who had stated that, when the home was short staffed, residents who had been up prior to supper, sitting in the lounge, had to wait until the staff put them to bed to be toileted; residents who required toileting before supper were not toileted if the home was short staffed; and 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.

During an interview with ADOC #138, they stated that the home's management had discussed the order with respect to toileting residents and had determined that the home did not have any residents on a toileting plan. The ADOC stated that the home's interpretation of a toileting plan did not encompass any resident currently in the home. The ADOC identified that prompted voiding was performed for residents; however, it was not listed as such in the care plan. The ADOC identified that no monitoring or auditing of the toileting of residents had occurred in the home.

During an interview with ADOC #111, they stated that there were no residents in the home who were on toileting routines other than the general times residents were toileted. The ADOC stated that a toileting routine referred to specific times a resident was toileted. They stated that, if a resident's plan of care identified they were to be toileted after meals and before bed, that would be specific to that resident so it would be a routine. They identified that no residents on the SCU or West Wing were on prompted voiding routines to promote continence, but that after meals, residents were generally toileted before being put back to bed. The ADOC identified that the home followed a traditional toileting process that was provided when PSWs toileted residents after lunch and after nourishment, and when they completed their rounds; that PSWs checked almost every resident every two hours and would take those who

required it to be toileted to manage continence. The ADOC acknowledged that the home had not implemented a routine monitoring process for the toileting of residents.

During an interview with the home's Administrator, they stated that the home had not completed any audits for the toileting of residents as they had thought that the order only pertained to one resident who had a scheduled toileting plan and not to the other residents in the home who were to be toileted before and after meals.

Inspector #625 reviewed the home's policies related to the toileting of residents which included the:
- "Continence Care and Bowel Management Program Direct Care Provider Procedure", printed January 3, 2013, that identified staff were to offer trips to the washroom for residents who were unable to toilet independently;
- "Bladder Retraining Procedure", printed January 3, 2013, that defined bladder retraining programs as most appropriate for residents with urgent urinary incontinence; and most effective for residents who were alert, could fully understand, communicate and were able to follow instructions. The procedure indicated that bladder retraining used scheduled voiding to restore normal bladder function or to improve continence.
- "Prompted Voiding Procedure", printed October 29, 2013, that identified prompted voiding as a behavioual intervention used to treat residents with stress, urge and functional urinary incontinence; and was most successful for residents with physical and/or cognitive deficits who would respond to timely reminders from caregivers. This technique involved prompting an individuals to use the toilet at regular intervals to encourage the maintenance of bladder control.
- "Toileting Routine Procedure", printed October 29, 2013, that defined toileting routines as most appropriate for residents with urge urinary incontinence and noted that an individualized toileting routine could be established for residents who had the ability to be toileted as exhibited by a prompted voiding trial. Residents were to be toileted based on the individual resident's pattern at the following times: upon awakening in the morning, after breakfast, before or after lunch, before or after supper, at bedtime and during the night if the resident was awake.

With respect to part (e) of the order, the licensee failed to develop and implement routine monitoring processes for the toileting of residents.

(ii) Bedtime and Rest Routines
The Inspector reviewed the grounds used to support CO #002 from inspection

#2018_703625_0007, which included a PSW interview that identified, when the home had worked short staffed on a particular date, two residents could not be transferred to bed during the evening shift but had to wait until the night shift staff arrived to assist them to bed.

During an interview with ADOC #138, they stated that they had not monitored the sleep and rest routines of residents in the home, nor had they created a monitoring process to do so.

During an interview with ADOC #111, when asked about the monitoring that the home had completed with respect to sleep and rest routines, they stated that residents' sleep and rest routines could be found in their care plans and that the home had no complaints that residents were not put to bed on time.

With respect to part (e) of the order, the licensee failed to develop and implement routine monitoring processes for the bedtime and rest routines of residents.

(F) With respect to part (f) of the order, the licensee was ordered to maintain records of the monitoring processes and the actions taken to rectify identified deficiencies with respect to the toileting of residents and the bedtime and rest routines of residents. The records were to 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. The licensee failed to complete any monitoring and maintain any related monitoring. See section (E) for further details.

The Severity of this issue was determined to be a level two, minimum harm or potential for harm. The scope of this issue was a level 3, widespread. The home had a level 4 history of ongoing non-compliance with this section of the Regulations that included:

• A Director Referral (DR) and Compliance Order (CO) issued during inspections # 2018_703625_0007, commencing April 17, 2018, and inspection #2018_509617_0004, commencing on January 30, 2018.
(625)

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

Jan 15, 2019(A3)

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant: 2018_703625_0007, CO #004;

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 comply with r. 36. of the Ontario Regulations 79/10.

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

Specifically the licensee must:
(a) Ensure that all staff receive training on the safe and correct use of equipment in use in the home, including mechanical lifts and related accessories, including transfer sling sizing, prior to performing their responsibilities;
(b) Ensure that all staff receive retraining 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 corrective 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.

During inspection #2018_703625_0007, compliance order #004 was issued to the home to address the licensee's failure to comply with r. 36. of the Ontario Regulation 79/10. The CO ordered the home to:

(a) Ensure that all staff received training in the safe and correct use of equipment, including mechanical lifts, prior to performing their responsibilities;
(b) Ensure that all staff received 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.

The compliance due date of this order was July 15, 2018.

The licensee completed part c of the order; however, the licensee failed to completed parts a, b and d.

(i) Safe Transferring

A) On a particular date, Inspector #625 observed PSW #139 and RPN #140 transfer resident #023 using a specific transfer device. The Inspector noted that a specific accessory of the transfer device was not used during the transfer and that the resident had a specific item between their body and a component of the transfer device.

A review of resident #023's current care plan identified that staff used "a specific transfer device. Place a specific item between the residents body and a component of the transfer device". The resident's most recent physiotherapy assessment identified their transfer status as a separate transfer device.

Inspector reviewed the transfer devices "Operating and Product Care Manual" which indicated:
- The transfer device should always be handled by a trained care giver … in accordance with the instructions outlined in these Operating and Care Instructions”;
- Warning: READ BEFORE USE. Before using the transfer device you must read and fully understand these Operating and Product Care Instructions. You must be trained on the device, and any accessories as well as its functions and controls;
- The Operating and Product Care Instructions are mandatory for the safe and effective handling of the transfer device, including the safety of the resident and the caregiver”;
- "Warning: Failure to follow these instructions may result in injury …";
- Accessory used to ensure that the lower part of the resident's body stays close to the transfer device.
- Warning: An assessment must be made for each individual resident being raised by the transfer device - by a medically qualified person - as to whether the resident requires the specific accessory when using the transfer device.

During interviews with PSW #132, they stated that 90 per cent of the time they felt that resident #023 transferred unsafely using specific transfer device. PSW #132

identified that, in their opinion, most residents who used the transfer device did not transfer safely and that they used the specific transfer device with resident #023 for everything except transferring the resident at a specific time of day as the resident asked for the specific transfer device to be used. The PSW also stated that they did not use the transfer device's accessory when transferring residents #023, #024 or #005 because the residents did not want or like the accessory being used.

During interviews with PSW #141 they stated that staff did not use the transfer device's accessory on residents, including resident #002, when using the transfer device as most residents did not want it to be used or refused to use it. The PSW stated they were aware that resident #023 had an item placed in between their body and the transfer device as a particular body part was sore and it stopped it from pressing against the transfer device. The PSW discussed that residents wanted to keep using transfer device as they still wanted to be toileted, not many residents had adaptive clothing to use for toileting with a separate transfer device and it would take additional time for staff to toilet residents using the separate transfer device. When asked for the transfer device's "Operating and Product Care Manual", the PSW stated they would ask Maintenance and returned to the Inspector with the manual stating it took a great deal of effort to find the manual.

During interviews with PSW #100, they stated that they did not normally use the accessory on the transfer device when transferring residents, including resident #002. The PSW stated they thought that, if they used the accessory, it would be considered a restraint and they would be required to sign for their application.

During an interview with resident #023, they stated that they used a specific transfer device at a particular time of day, and a separate transfer device for assistance with a specific type of care. The indicated that they did not want to use the accessory and that they did not use the accessory when using the transfer device as staff did not apply it.

During an interview with resident #024, they stated that they had told staff they did not want the accessory used when transferring with a specific device and that staff did not use the accessory.

During an interview with resident #002 they identified that staff did not use the accessory when transferring them using a transfer device.

During an interview with PSW #142, one of the three PSWs who provided lift and transfer training to staff in the home, they stated that staff were to apply the accessory when using the specified transfer device. The PSW acknowledged that residents should consider using a different type of transfer device when they did not want to use the transfer device as it was required. The PSW stated that, they were not sure if the transfer device's manual indicated if the accessory was required or not and they did not have a copy of the manual on the unit.

During interviews with PSW #139, one of the three PSWs who provided lift and transfer training to staff in the home, they stated that they did not use the accessory when transferring residents #023, 024 or #005 and acknowledged that resident #023 used an item between their body and the transfer device at the resident's request. The PSW acknowledged that the most recent physiotherapy assessment, identified resident #023 used a specific transfer device. They also acknowledged that the transfer device's manual identified that an assessment was required for each resident by a medically qualified person as to whether the accessory was required when using the transfer device. The PSW identified that they followed the resident's verbalized wishes on the use of the accessory, and not the directions detailed in the manual.

During an interview with RN #112, they stated that resident #023 could not use a specified device if they used a particular transfer device. The RN was not aware if there was a specific accessory to use with the transfer devices but stated that having one would be useful. The RN stated they were aware that resident #023 did not use the accessory and used an item between their body and the transfer device when transferring. The RN stated that they would not say whether it was safe for residents #023, #024 and #005 to not use the accessory on the particular transfer device but that the accessory was not used unless a resident's feet lifted up during the transfer. The RN acknowledged that a quarterly physiotherapy assessment had identified that resident #023 used a specific transfer device, but that the staff transferred the resident using a different transfer device.

During an interview with PTA #122, they identified that resident #023 had used particular transfer device, then experienced increased pain. Following a requested transfer assessment, the physiotherapist identified the resident required a different transfer device. The physiotherapist assessment of the transfer method did not identify that the accessory was not required or that an item was to be used, but that the resident required a specific transfer device.

During an interview with PTA #123, they stated that resident #023's physiotherapy assessment identified that a specific transfer device was required and that it should have been used for all transfers. PTA #123 indicated that pain was a factor as to why the transfer device was assessed as the appropriate transfer method. The PTA stated that the physiotherapist was asked about the use of the accessory on the transfer device and identified that it should be used for safety.

PTA #123 also commented that resident #024's current physiotherapy assessment identified that a specific device was required for transfers but did not reference that the resident's transfer should be modified to exclude the use of the accessory. The PTA also identified that, during an assessment by the Physiotherapist they had not indicated that resident #002 did not require the accessory when using the transfer device and that the direction not to use the accessory was not identified in the Physical Therapy or ADL Assistance care plans, or the most recent physiotherapy assessment.

During an interview with Inspector #625, ADOC #111 stated that they had completed monitoring of resident transferring techniques and identified that staff had not used the accessory with the specific transfer device during one of four monitoring entries, or 25 per cent of the monitoring entries, and that they had provided reinstruction to the staff that the accessory should have been applied. The ADOC further stated that staff should not use an item between a resident's body and the transfer device, unless the manufacturer had identified it was to be used, and that if a resident experienced pain during a transfer, the resident should be assessed for another more appropriate type of transfer device that did not hurt them. The ADOC acknowledged that the transferring techniques observed by the Inspector, including the use of an item between the resident and the device, and lack of use of the accessories, were not safe transferring techniques.

During an interview with the DOC, they stated that they used the accessory when using the specific transfer device and that all staff should use the accessory when transferring residents with the device. They further stated that they had discussed the use of the accessory with the staff and had identified to the staff that the use of the accessory was not a decision that a resident could make [as staff had stated to the Inspector that it was a “resident right” to refuse the use of the accessory].

During an interview with Staff Health Nurse #143, the individual who had provided

the "train-the-trainer" instruction on lifts and transfers to the home's three PSW trainers, they stated that they were not familiar with the transfer device's "Operating and Product Care Manual". With respect to the use of the accessory, they stated they had directed the DOC to refer to the home's procedure, which did not identify that the accessory was to be applied, but that not all transfer devices had the specified accessory. They then stated that the Client Mobility Assessment the home used should have addressed the use of the accessory but did not. The Staff Health Nurse indicated that, if the operating manual identified that the specified accessory was to be used and the residents had not been assessed not to use it, as identified in the manual, it should be used, as not using it would be unsafe. They also stated that it was not a safe transferring practice for staff to use the specific transfer device on a resident who had been assessed by a Physiotherapist as requiring a different device for transfers, or to use an item positioned between a resident and the device. They stated that they hoped the staff in the home had access to the lift manuals but were not sure if they did and could not locate the manuals where they had expected they would be located.

B) On July 18, 2018, Inspector #625 observed resident #023 using a mobility aid with a specified accessory. The Inspector noted the accessory hanging in close proximity to the mobility aid's wheel.

During an interview with PTA #122, they stated that they had observed resident #023 using their mobility aid with the accessory hanging down on previous occasions, and they were concerned that the accessory would be caught in the wheel and the accessory would pull the resident from their mobility aid.

During an interview with ADOC #111, they observed resident #023 with their accessory dangling near the front wheel of the resident's mobility aid. The ADOC acknowledged that the positioning of the accessory was unsafe for the resident, who used their mobility aid independently.

During an interview with the DOC, they also observed resident #023 with the accessory dangling in front on the mobility aid's wheel. The DOC identified that the accessory was unsafely placed and could become caught in the wheel causing the resident to fall from their mobility aid.

Inspector #625 reviewed the accessories user manual which identified that:
- the [resident] must be assessed by a competent person who must be fully trained in

the suitability, application and fitting of the accessory. Carers should always be trained in the use of accessory;
- the label on the accessory contains vital information to identify the accessory - if any part of the label becomes illegible, then in must be removed from service and replaced;
- the accessory should be visually inspected with regard to the label being clearly legible; and
- once the [resident] is in the chair, the accessory can be tucked away in storage points to prevent it from trailing on the floor or snagging in the wheels.

Inspector #625 observed two accessories in the clean utility room on July 18, 19 and 24, 2018, both of which had missing labels.

During an interview with PSW #139 they acknowledged that resident #023 had been unsafely positioned due to the location of their accessory. PSW #139 identified that they had not been familiar with the user manual but, after reviewing it with the Inspector, would follow the directions provided regarding placement of the accessory and legibility of the accessory labels, removing the two accessories from the clean utility room.

During an interview with the Staff Health Nurse #143, they identified that they had provided training on safe transferring and positioning techniques in a “train the trainer” capacity to three staff from the home, including PSW #139. The Staff Health Nurse identified that they had not read the accessories user manual and were not familiar with that accessory. They stated that placement of accessory in close proximity to the wheels of a mobility device was not a safe positioning technique and the accessory should always be tucked in. Additionally, Staff Health Nurse #143 acknowledged that a visual inspection of the accessories in use should be completed to ensure that the labels [which the manufacturer identified contained vital information to identify the accessory] were in place and clearly legible. The Staff Health Nurse stated that they had provided generic training for all licensee sites and that the Inspector had identified areas and equipment that the licensee had not provided training to staff on.

C) On July 18, 2018, Inspector #625 observed PSWs #132, #139 and #144 transfer resident #025 from their wheelchair to their bed using a specific transfer device. PSW #132 had requested the assistance of PSW #139 who was a trainer in the use of mechanical lifts as it was their first time using the transfer device. During the first

transfer attempt, PSW #139 selected specific points on the accessory. The transfer was not completed successfully as the accessory appeared large on the resident, it was poorly positioned and the resident's buttocks were slipping from the accessory while their arms and legs were being lifted. For the safety of the resident, the Inspector drew the PSWs' attention to the resident's buttocks, which had not completely left their mobility aid, despite the accessory and limbs being raised. The resident was immediately lowered back to their mobility aid with their buttocks now positioned at the edge of the seat which resulted in the three PSWs boosting the resident up in the mobility device manually. During the second transfer attempt, PSW #139 instructed the staff to put the points of the accessory on differently, and the resident was transferred from their mobility device to their bed.

A review of resident #025's health care record identified the residents most recent weight, taken a number of days prior to the observed transfer.

The Inspector reviewed the sling used during the transfer and identified it was a specific sized sling which had a label listing the weight guideline as a specific number of kilograms. The sling contained a label identifying that a specific sling was the appropriate sling size for resident #025's weight.

Inspector #625 reviewed the licensee's policy titled "Minimal Lift Procedure – ORG-III-NGE-15.01" effective January 30, 2018. The policy included a section on selecting the correct accessory size which indicated that the accessory was compatible with the lift device and the resident weight, and that the accessory weight rating should be legible on the tag. The policy identified that, when using a specific transfer devices staff should refer to the manual for the specific device being used before operating the device; manuals can be found on the shared network Q-drive under 'Client Lift Manuals'".

During interviews with PSWs #139, #126, #110 and #145, they stated that PSWs did not have computer access and they were not able to access transfer device and accessory manuals on a shared drive of a computer. The PSWs stated they were not aware of how they could access the manuals.

During interviews with RPN #146 and RN #106, both accessed the shared Q drive in the Inspector's presence but were not able to locate a folder or file titled "Client Lift Manuals", and were not able to locate the manuals.

The Inspector also reviewed the transfer devices user manual that read:
- visibly inspect the accessory prior to each use to ensure the accessory is the correct type, size and design to handle lifting....that the accessories straps were correctly attached to the spreader bar; and that the accessory was tested with the resident in it at a few inches over bed or chair prior to actual lifting;
- read the Accessory Guide, which is separate from this manual. Most accidents occur from wrong accessory size or type. Make certain you understand how to select, attach, inspect and test accessories;
- ensure accessories are sized appropriately and attached appropriately to the resident and lift. Failure to follow these instructions could result in serious injury.
- before placing the transfer device in service, require all personnel who will work with the lift to read the User's Manual;
- Ensure caregivers are trained and have read and understand the user manual and have demonstrated proper usage;
- READ SEPARATE ACCESSORY USER GUIDE FOR INFORMATION ON SELECTING, ATTACHING AND USING TRANSFER DEVICES WITH ACCESSORIES; and
- NOTE: Lift resident 1-2 inches over bed or chair, stop and then check that all points are secure, the accessory is holding the resident before further lifting. WRONG ACCESSORY SIZE CAN ALLOW RESIDENT TO FALL OUT - READ ACCESSORY USER GUIDE.

The manual also contained the specific instructions on the accessory use as follows:
- to lift the resident in a seated position, use a shorter set of loops at the shoulders and a larger set of loops at the legs. This places the resident's head higher than their legs. Resident must have some upper body strength to be in seated position or risk of falling out is possible; and
- to lift in a reclined position, use a longer set of loops at the shoulders and a shorter set of loops at the legs. This will allow the resident's head to be level with their legs.

The Inspector next reviewed the accessory guide that:
- read WARNING: Read accessory manuals carefully - Failure to use appropriate accessory, attach it properly, or inspect it for wear and tear can result in serious injury"; and
- listed the use weight guidelines for a proper fit as a small red sling for 34 to 56 kgs, a medium yellow sling for 57 to 79 kgs, and a large green sling for 80 to 113 kgs.

During an interview with PSW #132, they stated that they did not know about

different types of accessories and when to use them.

During an interview with PSW #128, they stated they did not compare residents' weights to listed accessory weight ranges, but would see how the accessory fit and adjust it.

During an interview with PSW #148, they stated they would try an accessory, use it and adjust it if needed.

During an interview with PSW #149, they stated that the accessory use was based on their judgement and identified a small accessory as having an identifying colour [the small accessories used with a specific transfer device and a separate device was identified with the a specific colour].

During an interview with PSW #139, who trained the home's staff on safe transferring and positioning techniques, they stated that they didn't recall being given training on the use of different accessories in the same transfer.

During an interview with RPN #146, they stated that they assisted with transfers using mechanical lifts but did not know about different types of a specific accessory.

During an interview with RN #150, they stated that they were aware that there were different types of accessories but did not know the different types or when to use them.

During an interview with RN #106, they stated that they were not familiar with a part of the accessory, or with the colours that corresponded to the accessory.

During an interview with PSW #139, they identified that they had been provided training on a specific transfer device from PSW #147 who had instructed the PSW to use all of the same points when attaching the accessory to the transfer device but was not sure why they were to do so. The PSW stated the first transfer attempt involving resident #025 "felt totally unsafe" and that the resident's buttocks were not positioned properly in the accessory. The PSW identified that they had selected specific points of the accessory for use as those closest to the resident's body without straining the body were for sitting and that a different point of the accessory was better for laying down. The PSW didn't recall being given training on the use of different points of the accessory in the same transfer. The PSW verified that resident

#025’s recent weight was recorded as a specific number in July 2018 and the accessory they had used to transfer the resident was a specific size intended for use with residents whose weights were in a specified weight range. The PSW stated that resident #025’s weight identified that they were to use a specific size of accessory but that a different sized accessory was the only one the home had to use with that specific transfer device.

During an interview with the DOC, they stated that PSW #147 had attended training on the transfer device with Administrative Assistant #135. The DOC identified that the training entailed bringing the device into the office, having a video conference with the vendor and watching videos on the transfer device.

During an interview with Staff Health Nurse #143, they identified that they had provided training on safe transferring and positioning techniques in a “train the trainer” capacity to three staff from the home. They stated that they had not read the transfer device's manual or the corresponding accessory guide as the device was not in service at the time of the training. The Staff Health Nurse indicated that they did not know of any training completed on the specific device and, as far as they knew, arrangements were made for the specific device training and their supervisor, the Occupational Health and Safety Coordinator #120 had asked to be notified when training was provided so they would all be on the same page. The Staff Health Nurse identified that the use of the device's accessory was determined based on the height of the resident, their comfort level and discussion with the people that do the lifting. They identified that the accessory was usually used in a particular manner and they didn’t know if there was anything in writing that said what points of the accessory to use. They identified that staff should use the accessory that fits the weight of the resident, that a incorrect fitting sling on a person could cause injury and discomfort and, they hoped, with the accessory used in a particular manner, that a larger accessory for a smaller person would not result in the resident falling out of the accessory.

(ii) Training

In respect to parts "a" and "b" of the CO, the licensee was to ensure that all staff received training in the safe and correct use of equipment, including mechanical lifts, prior to performing their responsibilities; and, ensure that all staff received retraining annually in the safe and correct use of equipment, including mechanical lifts.

During the inspection, Inspector #625 observed the home's staff use a transfer device's accessory unsafely, a specific transfer device unsafely, and use unsafe transfer techniques. Refer to section (i) of this finding for further details.

A) During interviews with the home's staff regarding the training they had been provided with respect to the mechanical lifts and slings in use, Inspector #625 discovered:
- RN #134 had training on one transfer device but was not sure if it was the regular transfer device or a different transfer device;
- PSWs #126 and #110 had not been trained on a specific transfer device;
- RN #106 had not been trained on a specific transfer device, but had participated in a transfer using the device; and,
- multiple staff, including PSWs, RPNs and RNs had not been trained on the correct sizing and types of accessories in use.

During interviews with the home's staff, it was identified that the home had acquired and put into service a new transfer device.

A review of Education Attendance Sheets for the specific transfer devices dated in May and June 2018, identified 26 staff listed on the training sheets as having attended the training.

A review of the Surge Learning training list provided by the home identified that 92 staff had attended the home's Minimal Lift training, which did not include training on the new transfer device.

The documentation provided to the Inspector did not identify that 66 out of the 92 staff, or 72 per cent of the staff, had received training on the new transfer device.

During an interview with the DOC, they stated that not all of the home's staff had been trained on use of the transfer device.

B) Inspector #625 reviewed the licensee's policy titled "Minimal Lift Procedure – ORG-III-NGE-15.01" effective January 30, 2018, which identified that, as the first step to using transfer devices that staff were to "refer to the manual for the specific transfer devices being used before operating the device; manuals can be found on the shared network Q-drive under 'Client Lift Manuals'".

During interviews with PSWs #139, #126, #110 and #145, they stated that PSWs did not have computer access and they were not able to access transfer device and accessory manuals if they were stored on a shared drive of a computer. The PSWs stated they were not aware of how they could access the manuals.

During interviews with RPN #146 and RN #106, both accessed the shared Q drive in the Inspector's presence but were not able to locate a folder or file titled "Client Lift Manuals", and were not able to locate the manuals.

During an interview with PSW #141, they offered to find a copy of a specific devices "Product Care Instructions manual" for the Inspector. The PSW left the unit and, when they returned, they stated that they had to ask Maintenance for a copy and that it "took a great deal of effort to find the manual".

During an interview with the Staff Health Nurse #143, the employee who had provided the home's trainers with "train-the-trainer" education on safe transferring and positioning techniques, they stated that they did not know how staff would access the transfer device and accessory manuals for the equipment in use in the home. They checked one electronic location where they believed the manuals may have been uploaded to provide staff access to them and identified that they were not present. The Staff Health Nurse identified that they had not read and were not familiar with specific transfer device's operating and product care instructions manuals. The Staff Health Nurse identified that the training they had provided to the trainers was generic and done for multiple facilities of the licensee. They also stated that there had to be more to the training as there were areas and equipment that they had not trained on.

In conclusion, with respect to parts (a) and (b) of the order, the licensee failed to (a) ensure that all staff receive training in the safe and correct use of equipment, including transfer devices, prior to performing their responsibilities; and (b) ensure that all staff received retraining annually in the same and correct use of equipment, including mechanical lifts. The licensee did not provide training that addressed the specific equipment in use in the home to ensure that it was safely and correctly used, nor did the and the licensee train all staff on a specific device before putting it into use and before the untrained staff used the lift.

(iii) Audit Record

With respect to part "d" of the order, the licensee was required to maintain records of a routine monitoring process that they had developed and implemented for the use of safe transferring techniques. The records were to 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.

Inspector #625 reviewed an audit sheet developed by the home titled "Focused Audit for Proper Use of Lift Equipment". The audit sheet did not include areas for the names of residents involved or the outcome of the auditing observations.

One audit completed by ADOC #111 identified that staff had not demonstrated proper use of a sit to stand lift on a particular date, as they had failed to apply an accessory until reminded. Staff educated on the implications and expectations".

Another audit completed by ADOC #138 identified that they had reminded staff member to a specific accessory prior to engaging the transfer device on a particular date.

Neither audit listed the names of the residents involved or the outcome of the audits, such as observing the compliance of the staff with the use of leg straps on other occasions to ensure that reinstruction had been effective.

During this inspection [which began five days after ADOC #111's observation of staff not applying the accessories when using a transfer device], through observations and staff interviews, Inspector #625 identified that multiple staff did not apply the accessory when using the transfer device. The outcome of the reinstruction to staff to use the accessory on the particular transfer device had not been identified by the home and the staff had continued to use the device in an unsafe manner. [s. 36.]

The severity of this issue was determined to be a level 2, minimum harm or potential for harm. The scope of this issue was a level 3, widespread. The home had a level 4 history of ongoing non-compliance with this section of the Regulations that included:

• A Compliance Order (CO) issued during inspection #2018_703625_0007, commencing on April 17, 2018;
• A Voluntary Plan of Correction (VPC) issued during inspection #2017_624196_0017, commencing on November 20, 2017. (625)

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

Jan 15, 2019(A3)

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2018_703625_0009, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The Licensee must comply with s. 6 (4) of the LTCHA, 2007.

The licensee shall ensure that the staff involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Specifically the licensee must:
(a) Conduct an audit of the residents in the home who were not involved in the Novo Peak physiotherapy program to ensure that their physiotherapy assessments are current and have been completed as required including initial assessments, quarterly assessments, reassessments following a change in resident status and post fall assessments.
(b) For any residents identified as not having a current physiotherapy assessment, or reassessment, ensure that the assessment is completed.
(c) Maintain records of the actions taken with respect to this order.

Grounds / Motifs :

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

During inspection #2018_703625_0009, compliance order #001 was issued to the home to address the licensee's failure to comply with s. 6. (4) (a) of the Long Term Care Home's Act, 2007. The CO ordered the home to:

Ensure that the staff involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

The licensee was specifically ordered to:

(a) Conduct an audit of the residents in the home to ensure that their physiotherapy assessments were current and had been completed as required, including initial assessments, quarterly assessments, reassessments following a change in resident

status and assessments post-falls.

(b) For any residents identified that did not have a current physiotherapy assessment/reassessment, ensure that the assessment was completed.

(c) Develop and implement a tracking system that ensured that required physiotherapy assessments were completed and documented in GoldCare in a timely manner.

(d) Maintain records of the actions taken with respect to this order.”

The compliance due date of this order was July 15, 2018.

The licensee completed part c and d of the compliance order; however, the licensee failed to complete part a and b.

1. In part “a” of the compliance order, the licensee was ordered to conduct an audit of the residents in the home to ensure that their physiotherapy assessments were current and had been completed as required, including initial assessments, quarterly assessments, reassessments following a change in resident status and assessments post-falls.

During a review of the home’s documentation with respect to part “a” of the order, Inspector #621 identified a document titled “MOHLTC plan Order #1 Physio”, that Novo Peak Health (NPH), a contract physiotherapy service provider, completed an audit of all residents currently in their physiotherapy program. The assessment included the date of referral, assessments completed since January 2018, the initial assessment date, and whether the resident was discharged from the program. The document however, did not identify that an audit was completed of all residents in the home.

During interviews with Physiotherapy Assistants (PTA’s) #122 and #123, they reported to Inspector #621 that an audit had been completed to review the assessment and reassessment status of residents who were actively in a physiotherapy program with NPH since January 2018. PTA’s #122 and #123 confirmed to the Inspector that the audit that had been completed for the compliance order did not include residents in the home who had not been referred to NPH either on or after January 1, 2018. Further, PTA’s #122 and #123 informed the Inspector

that the home's staff were required to complete a referral using NPH's paper referral form before their Physiotherapist completed an assessment of a resident to determine eligibility for the program.

During an interview with the Chief Executive Officer (CEO) of NPH, they reported to Inspector #621 and #625 that based on their interpretation of the order, a decision was made to focus the audit on those residents in the home who had been referred by the home for physiotherapy assessment, and were already part of their program. The CEO reported to the Inspectors that they could run a report from a software program identified as Colligo, to determine the assessment status of those residents in the home who were not part of their program.

Inspector #621 reviewed the contract between NPH and the home, which identified that NPH became the contract service provider of Physiotherapy Services in the home effective November 1, 2016.

During a subsequent interview with PTA #122, they provided Inspector #621 with a record which identified that as of a particular date, 31 residents in the home who were not part of an active physiotherapy program with NPH, and of those, 13 residents had never had an initial assessment completed by NPH after they took over Physiotherapy Services in the home.

During an interview with the Administrator, they reported to Inspector #621 that it was their expectation that after NPH assumed the contract to provide Physiotherapy Services in the home, a baseline assessment had been completed of all residents, in order for NPH to independently determine whether residents not active in their program, continued to not require their program and services. As a consequence, the audit completed as part of the order did not include those residents who were not currently on the NPH program.

2. In part "b" of the order the licensee was ordered to ensure that an assessment was completed for any residents identified to not have a current physiotherapy assessment/reassessment.

During an interview with PTA #122, they reported to Inspector #621 that as of a particular date, there were 31 residents in the home who were not part of an active physiotherapy program with NPH, and of those, 13 residents never had an initial assessment completed after NPH took over Physiotherapy Services in the home in

late 2016. Additionally, PTA #122 identified that the program did not assess residents for eligibility to the program, unless a referral was made by the home to them.

During an interview with RN #106, they confirmed to Inspector #621 that NPH did not assess any resident unless the home's staff completed and sent the required Novo Peak referral form to the program. During a review of health records by RN #106, they confirmed the following for nine of the 13 residents identified by PTA #122 to have not been assessed by NPH after November 1, 2016:

- Resident #014 was admitted to the home on a particular date, and a NPH Physiotherapy (PT) referral was not sent to the program at any time after the resident's admission;

- Resident #015 was admitted on a particular date. Documentation identified that the home's former PT was involved with the resident until a particular date; however, there was no PT referral sent to NPH for re-assessment after a particular date. RN #106 identified that resident #015 would have benefited from a PT reassessment by NPH as the resident had specific diagnosis and had utilized a mobility aid since their admission;

- Resident #016 was admitted on a particular date, and no NPH PT referral was sent at any time after the resident's admission;

- Resident #009 was admitted on a particular date. Documentation identified that the home's former PT was involved with the resident until a specific date; however, there was no PT referral to NPH for re-assessment after a particular date. RN #106 identified that resident #009 would have benefited from a PT reassessment as the resident utilized a mobility aid.

- Resident #018 was admitted on a particular date. Documentation identified that the home's former PT was involved with the resident until a particular date. Additionally, there was no further documentation that the resident was discharged from PT services any time after a particular date, and there was no PT referral to NPH for re-assessment after a particular date. Further, RN #106 identified that resident #018 would have benefited from a PT re-assessment, as the resident utilized a mobility aid.

- Resident #019 was admitted on a particular date, with documentation identifying

that the home's PT had been notified at that time. RN #106 confirmed that there was no further documentation from the home's PT after a specific date, and that there was no PT referral sent to NPH for re-assessment after a particular date.

- Resident #020 was admitted on a particular date. Documentation identified that the home's former PT was involved with the resident until a particular date; however, there was no record that the resident was discharged from PT services at any time thereafter. Additionally, there was no PT referral to NPH for reassessment of resident after a particular date. Further, RN #106 reported that resident #020 would have benefited from a PT reassessment as the resident utilized a mobility aid, and was at a specified level of risk for falls;

- Resident #021 was admitted on a particular date. Documentation identified that a PT referral was sent; however, RN #106 confirmed that there was no copy of the referral on file, nor was there indication that the resident had an initial assessment from PT services on or shortly after their admission. RN #106 identified that another PT referral to NPH should have been sent, with a copy of the completed referral kept on the resident's chart for reference; and

- Resident #038 was admitted on a particular date. A PT referral was identified in the documentation to have been sent to NPH; however, there was no copy of the referral on file, nor was there indication that the resident had an initial assessment form PT services on or shortly after the admission. RN #106 identified that the resident would have benefited from assessment due to them being at a specific level of risk for falls, and utilizing a specific device for mobility. RN #106 indicated they would have expected that another PT referral was sent, if after the six week post admission care conference there was no documentation that an initial PT assessment was part of the resident's health record.

In follow up to the review, RN #106 confirmed to the Inspector that all nine residents did not have a current physiotherapy assessment/reassessment. Additionally, RN #106 verified that with no referral being sent to NPH to alert the program staff and help establish a baseline assessment of each resident's current physiotherapy needs, collaboration in the assessment of the resident with respect to physiotherapy care did not occur, and should have.

The severity of this issue was determined to be a level 2, minimum harm or potential for harm. The scope of the issue was a level 2, a pattern. The home had a level 4

history of non-compliance with this section of the Act that included:

- A Compliance Order (CO) issued during inspection #2018_703625_0009, commencing on April 17, 2018;
- A Voluntary Plan of Correction (VPC) issued during inspection #2016_246196_0001, commencing on January 4, 2016. (621)

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

Jan 15, 2019(A3)

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 31 day of October 2018 (A3)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by MICHELLE BERARDI - (A3)

Service Area Office / Bureau régional de services : Sudbury