Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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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
Feb 12, 2018;	2017_616542_0018 (A2)	009278-17, 009403-17, 009984-17, 014753-17, 016183-17, 017893-17, 018569-17, 021998-17, 022955-17, 023028-17, 023566-17, 024698-17, 024752-17	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 700 MARKHAM ON L3R 9W2

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

Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 4J3

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

SHELLEY MURPHY (684) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Extended compliance due date from March 2, 2018 to April 6, 2018.

Issued on this 12 day of February 2018 (A2)

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

Original report signed by the inspector.

Ontario

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

SHELLEY MURPHY (684) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 30 - November 9, 2017.

The following Complaint Logs were inspected during this inspection:

Five intakes related to; insufficient staffing levels in order to meet different needs of residents, fall prevention interventions, and residents not receiving their baths/showers.

Three intakes related to; improper care, resident rights, plan of care and assessments.

Four intakes related to; abuse, neglect, foot care, plan of care and cleanliness.

One intake related to the food production.

A Critical Incident (CI) inspection, inspection #2017_616542_0019 and a Follow Up Inspection, inspection #2017_616542_0020 were completed concurrently with this inspection. As a result, findings of non-compliance related to LTCHA, 2007,

s. 6. (7) and s. 20 (1) identified during the Complaint and Critical Incident Inspections will be addressed in the Follow Up Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, Acting Assistant Director of Care, Assistant Director of Care (ADOC), Dietary Manager, Registered Dietitian (RD), scheduling staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), 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, employee files, staffing assignments and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Sufficient Staffing

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

8 WN(s)
3 VPC(s)
4 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (1) This section and sections 32 to 47 apply to,
(a) the organized program of nursing services required under clause 8 (1) (a) of the Act; and O. Reg. 79/10, s. 31 (1).
(b) the organized program of personal support services required under clause 8 (1) (b) of the Act. O. Reg. 79/10, s. 31 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Inspector #542 reviewed numerous complaints that were submitted to the Director outlining concerns that the home was not meeting the needs of the residents. The complainants all indicated that the home was often working without a full complement of Personal Support Workers (PSWs) and that residents were not receiving their scheduled baths or showers, scheduled nourishments, toileting needs, skin assessments and repositioning as per their care plans.

On October 31, 2017, and on November 6, 2017, Inspector #542 interviewed scheduling clerk #105, #143 and #144. They were asked to provide the Inspector with documentation that indicated when and where the home was working without a full complement of PSW staff. Inspector #542 reviewed the documentation and noted that during a five week period in 2017, the home was short three or more PSWs on seven separate occasions on various units throughout the home. Furthermore, during a weekend in October 2017, during a day shift, the home was short six PSWs on both days.

On October 30, 2017, Inspector #542 reviewed resident #035's progress notes and found that on a specific day in August, 2017, it was documented that they did not receive their shower due to a staffing situation. Inspector #542 reviewed the document that was provided by scheduling clerk #105 which verified that the home was short 6 PSWs that same day in August, 2017.

On November 1, 2017, Inspector #542 reviewed the Activity of Daily Living (ADL) documentation for resident #036 who resided on a specific unit. It was noted that

during a seven day period in October, 2017, there was no documentation under the bathing heading to indicate that the resident had received their bath/shower for that week. A review of the head to toe skin assessments revealed that the last assessment was completed in October, 2017. The bath/shower assignment document had resident #036 listed for one shower/bath a week, during the day on Saturdays. A review of the current care plan revealed that resident #036 was to receive a bath/shower twice a week.

On November 1, 2017, Inspector #542 interviewed PSW #106 who worked the unit where resident #036 resided, for two days in October, 2017, during the day shift and then accepted an evening overtime shift on one of those days on a different unit. PSW #106 indicated that it was very difficult to complete all care for the residents as they were working short PSW staff. PSW #106 verified that they were unable to complete some of the baths for the residents on the specific unit for both day shifts. PSW #106 also indicated that during the evening shift on the other unit, they were also unable to complete the baths/showers for the residents.

Inspector #542 interviewed PSW #114 who worked on the same weekend in October, 2017, during the evening shift on the same unit that resident #036 resided on. They indicated that they tried their best to complete all of the care for the residents; however, as a result of being short staffed, they were unable to complete showers for resident #020 and #021. Inspector #542 asked if there was any other resident care that was impacted by working without a full complement of PSWs. PSW #114 indicated that residents had to wait longer for assistance, and nourishment was not always provided to the residents. They indicated that it was very difficult to complete the care.

Inspector #542 reviewed the ADL document, under the bathing section for resident #020, who resided on the same unit as above and noted that there was no documentation that indicated that resident #020 had received their scheduled bath on a specific day in October, 2017. A review of the head to toe skin assessments also revealed no documentation that indicated that this was completed. A review of the current care plan for resident #020 revealed that they preferred to be showered and required assistance by one staff.

Inspector #542 reviewed the health care record for resident #021, who also resided on the same unit. The bathing assignment document indicated that resident #021 was to receive their shower on a specific evening in October, 2017. The ADL document from the specific evening in October, did not indicate that the resident

received their shower but rather a bed bath. A review of resident #021's current care plan verified that they preferred showers and required assistance by one staff member and two staff for transfers.

On November 1, 2017, Inspector #542 interviewed PSW #135. They indicated that they frequently worked without a full complement of PSW staff and that it was impossible to complete all of the required care for the residents. PSW #135 indicated that at times they were unable to deliver the scheduled nourishments to the residents and that they had to complete bed baths even if this was not what the resident preferred. They also indicated that when the ADL documents were blank it was because nothing was completed.

Inspector #542 interviewed RPN #113 who indicated that they worked on a specific day shift in October 2017, on a different unit and an evening shift on another unit as the home was short staffed. They indicated that when they work short staffed, typically the scheduled baths/showers were not completed and bed baths were provided to the residents instead.

On November 2, 2017, Inspector #542 interviewed PSW #136 who also worked on a specific day in October, 2017, on a different unit. PSW #136 indicated that the nourishments were not provided to the residents on that unit as they were too short staffed. They indicated that only one shower was provided and the rest were not completed, again, due to short staffing.

Inspector #542, interviewed PSW #137 who was scheduled to work a shift in October, 2017 on a specific unit but was transferred to another unit as that unit was also short staffed. They indicated that residents were provided with bed baths instead of their scheduled showers/baths because they were working short. Inspector #542 asked what a bed bath consisted of. They described it as being a very quick wipe down, more like morning and bedtime care. PSW #137 also indicated that all residents on the unit had not received their nourishment.

Inspector #542 interviewed PSW #138 who worked on a specific unit in October, 2017. They indicated that they were unable to complete any of the showers or baths on that unit as they were working short PSW staff. They indicated that they were instructed to complete bed baths on all of the residents that were scheduled for a bath or shower that day. The bed bath consisted of basic care, like morning and bedtime care and not a real bed bath as they did not have the time. PSW #138 indicated that they provided some of the nourishment but not all, due to short

staffing.

Inspector #542 interviewed RPN #121 who also worked during the same day and unit as above. They indicated that it was a difficult shift as they were short PSW staff. They indicated that they were instructed to inform the PSWs to provide bed baths to the residents that were scheduled to have their bath or shower that day. Inspector #542 asked why resident #022 received a bed bath on a specific day in October, 2017. RPN #121 verified that it was because they did not have enough staff or time.

On November 2, 2017, Inspector #542 reviewed resident #022's care plan under the bathing heading. It was documented that resident #022 would be showered twice a week and that they preferred to be showered.

On November 2, 2017, Inspector #542 interviewed PSW #139 who worked during the day shift over a weekend in October, 2017, on a specific unit. PSW #139 indicated that resident #023 received a bed bath as they had not had enough time to provide them with a bath or a shower. PSW #139 also verified that the nourishments, two hour toileting routines and shaving were not completed for the residents on the unit that they worked on as they did not have a full complement of PSW staff.

Inspector #542 reviewed the health care record for resident #023 and noted that their current care plan indicated that resident #023 was to receive a shower with one staff assist.

Inspector #542 spoke with PSW #140, who also worked over a specific weekend in October, 2017, on a different unit. They indicated that they were unable to complete the baths and showers, as they had not had enough staff or time.

On November 1, 2017, Inspector #542 interviewed PSW #135 who indicated that the home often worked without a full complement of PSWs and that they often were not able to provide the residents with the scheduled nourishments and beverages.

On November 2, 2017, Inspector #542 interviewed PSW #137 who worked a day shift on a different unit on a specific day in October, 2017. PSW #137 indicated that they were unable to complete the nourishment/beverage round for the residents due to being short staffed.

Inspector #542 interviewed PSW #138 who worked on another unit, on a specific day in October, 2017. PSW #138 indicated that they were unable to provide the residents with the morning beverages during the nourishment round due to short staffing. PSW #138 indicated that the residents that had a labelled nourishment were the only ones that received anything.

On November 2, 2017, Inspector #542 reviewed the nourishment documentation from, October 28 and 29, 2017, on a specific unit for nine different residents (resident #025, #026, #027, #028, #029, #030, #031, #032 and #033). There was no documentation to support that any intake was consumed on either day with regards to the day time nourishment passes at 1000 hrs and 1400 hrs.

On November 3, 2017, Inspector #542 interviewed RN #120 who worked during the day shift, over a specific weekend in October, 2017. RN #120 indicated that the whole building was short PSW staff. The Inspector asked what the procedure was when the home was that short staffed. RN #120 indicated that they notified the Director of Care (DOC) and they were instructed to inform the staff to complete bed baths. RN #120 indicated that they were worried as they knew some of the family members would be upset to know that their loved ones had not received their scheduled bath or shower; therefore, they wanted to verify with management that it was okay. RN #120 indicated that the care of the residents suffered because they were short staffed, toileting routines and bathing schedules were not followed, also the residents had to wait a lot longer for assistance. At times, residents were brought to the dining rooms in their pajamas because of being short staffed; furthermore, PSW staff were running late getting to the dining room for meals due to not enough staff. They indicated that it was very upsetting that they could not always provide the care that the residents deserved.

On November 3, 2017, Inspector #542 was approached by resident #019. Resident #019 indicated that the home did not have enough staff and that the management team always said they were working on it but it just did not seem to be improving. Resident #019 indicated that sometimes they had to wait a long time for assistance with care and that they missed their baths because there was not enough staff. They also indicated that quite often they were late for meals and that there was not enough staff to assist the residents.

Inspector #542 spoke with a family member of resident #024, who expressed concerns regarding the staffing levels in the home. They indicated that there were

times when resident #024 had juice in their room from the evening before and the staff were unable to give the resident nourishment during the day as they were short staffed. The family member also indicated that resident #024's bed linens and clothing were often soiled because they were short staffed.

On November 3, 2017, Inspector #542 reviewed the progress notes for resident #024. On a specific day in October, 2017, it was documented that resident #024 was yelling as they needed assistance to use the bathroom. Resident #024 informed the RN that there was not enough staff in the building to assist the residents. In a subsequent progress note, documented also in October, 2017, a family member for resident #024 called and informed the staff that they had noticed that resident #024 would ring for assistance and that it would take a long time for staff to respond.

On November 7, 2017, Inspector #542 observed on a specific unit and noted that PSW #117 was not documenting any fluid intake on the "resident daily food and fluid intake" record under the, "Nourishment AM" section for each resident. Inspector #542 asked PSW #117 if the 1000 hours (hrs) beverages where provided to the residents. PSW #117 verified that they had not had the time to provide the residents with the 1000 hr beverages. Inspector #542 spoke with PSW #149 who also confirmed that they were unable to provide the 1000 hr scheduled beverages to the residents. PSW #117 and PSW #149, verified that blank documents indicated that the task was not completed.

On November 7, 2017, Inspector #542 reviewed the "resident daily food and fluid intake" record for resident #038. It was noted that for three days in November, 2017, there was no documentation to indicate that resident #038 had received any fluids during the am nourishment. Inspector #542 also reviewed resident #042, #043, #044, #045, #046 and #047's "daily food and fluid intake" records and noted that nothing was documented for the same three days in November, 2017, under the morning nourishment.

Inspector #542 observed that some of the residents were not present in the dining room during breakfast on a different unit. Inspector #542 interviewed PSW #117 who indicated that they were unable to get some of the resident's up into the dining room for breakfast as they had not had enough time. Resident #051, #052 and #053 were not present in the dining room for breakfast. PSW #117 also indicated that resident #046 and #054 were in the dining room in their pajamas because they had not had enough time to finish their morning care. Inspector #542 reviewed

resident #051's current care plan and noted that it was documented that they got up around 0800 hrs. Resident #053's care plan indicated that their usual wake time was at 0800 hrs. Resident #046 and #054's care plan did not indicate that they preferred to be dressed in their pajamas for breakfast.

Inspector #638 reviewed a complaint submitted to the Director related to staffing concerns within the home. The complaint outlined an incident on a specific day in October, 2017, where family came to visit resident #001 and found the resident still in bed at approximately 1010 hours. The complaint alleged that they were notified by staff that the facility was short staffed and that "we couldn't get everyone up for breakfast" and "we do our best, but this company will not provide enough staff".

Inspector #638 reviewed resident #001's care plan and identified an intervention under the "Sleep and rest" foci that staff were to ensure that resident #001 was up and in the dining room for breakfast each morning.

In an interview with Inspector #638, RPN #129 indicated that when a home area was short staffed it was common that some residents were not up for breakfast. They indicated this was because there was not enough staff available to provide care to each resident and ensure they were up in time for breakfast. The RPN indicated that they met with family regarding resident #001's concerns and indicated that they were short staffed and unable to ensure that the resident was up for breakfast.

During an interview with Inspector #638, RN #128 indicated that when the home was short staffed, the biggest issue was ensuring that all residents were up in the morning. The RN indicated that the direct care staff attempt to get everyone up for breakfast; however, this was not always possible due to the lack of available staff. The RN indicated that it was "probably valid" that they were too short sometimes to ensure that everyone who should have been up was up.

Inspector #542 interviewed the Administrator, Director of Care (DOC) and the Acting Assistant Director of Care (AADOC). Inspector #542 asked what the procedure was for calling in staff. The Administrator indicated that the scheduling clerk would inform the management team on Friday as to how the home was scheduled for the weekend. Also they would call the manager on call on the weekend if they were short staffed. The Administrator indicated that they had been having staffing issues since the summer and that the home has a contract with the "Plan A Agency" for assistance with filling some of the vacant shifts. Inspector

#542 asked when the home started reviewing the home's staffing plan. They indicated that they have been reviewing the staffing plan for approximately two weeks now. The Administrator indicated that when they were really short staffed, that they would call in extra staff the next day to assist; they have also had other support services staff come in and assist with feeding and other duties other than care related duties. Inspector #542 asked what occurred on the specific weekend in October, 2017, when the home was short six PSW's on both day shifts. The Administrator and the DOC indicated that they were not aware that the home was that short until Monday. Inspector #542 asked the Administrator what was done about it on Monday; they verified that nothing was done to address the staffing complements.

During a subsequent interview with the Administrator, Inspector #542 asked the Administrator if they felt that the home provided a staffing mix that was consistent with residents' assessed care and safety needs. The Administrator acknowledged that the home has had staffing problems during the weekends but felt that the home was well staffed from Monday to Friday. They indicated that approximately two weeks ago they started reviewing a specific unit as they recognized that this unit was very heavy with the care needs. The Administrator expressed that the home was considering moving some of the residents from that unit to another unit in attempt to adjust the workload. Inspector #542 asked the Administrator if they felt that the home had an organized program of personal support services for the home to meet the assessed needs of the residents. The Administrator responded, "yes, during the week we are meeting the needs of the residents, for the most part." Inspector #542 explained that during this inspection it had been identified that the residents were not receiving their scheduled baths or showers and the scheduled nourishments. Inspector #542 asked the Administrator again if they felt that the home had an organized program of personal support services to meet the assessed needs of the residents. The Administrator indicated that they could not answer that question. [s. 31. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On October 30, 2017, Inspector #542 reviewed resident #035's progress notes and found that on a specific day in August, 2017, it was documented that they did not receive their shower due to a staffing situation.

On November 1, 2017, Inspector #542 reviewed the Activity of Daily Living (ADL) documentation for resident #036 who resided on a specific unit. It was noted that during a seven day period in October, 2017, there was no documentation under the bathing heading to indicate that the resident had received their bath/shower for that week. The bath/shower assignment document had resident #036 listed for one shower/bath a week, during the day on Saturdays. A review of the current care plan revealed that resident #036 was to receive a bath/shower twice a week.

On November 1, 2017, Inspector #542 interviewed PSW #106 who worked the unit where resident #036 resided. PSW #106 worked on the unit for two days in October, 2017, during the day shift and then accepted an evening overtime shift on one of those days on a different unit. PSW #106 indicated that it was very difficult

to complete all care for the residents as they were working short PSW staff. PSW #106 verified that they were unable to complete some of the baths for the residents on the specific unit for both day shifts. PSW #106 also indicated that during the evening shift on the other unit on, they were also unable to complete the baths/showers for the residents.

Inspector #542 interviewed PSW #114 who worked on the same weekend in October, 2017 during the evening shift on the same unit that resident #036 resided on. They indicated that they tried their best to complete all of the care for the residents; however, as a result of being short staffed, they were unable to complete showers for resident #020 and #021. They indicated that it was very difficult to complete the care.

Inspector #542 reviewed the ADL document, under the bathing section for resident #020, who resided on the same unit as above and noted that there was no documentation that indicated that resident #020 had received their scheduled bath on a specific day in October, 2017. A review of the current care plan for resident #020 revealed that they preferred to be showered and required extensive assistance by one staff.

Inspector #542 reviewed the health care record for resident #021, who also resided on the same unit. The bathing assignment document indicated that resident #021 was to receive their shower on a specific evening in October, 2017. The ADL document from the specific day in October, did not indicate that the resident received their shower but rather a bed bath. A review of resident #021's current care plan verified that they preferred showers and required total assistance by one staff member and two staff for the transfer.

On November 1, 2017, Inspector #542 interviewed PSW #135. They indicated that they frequently worked without a full complement of PSW staff and that it was impossible to complete all of the required care for the residents. PSW #135 indicated that at times they had to complete bed baths, even if this was not what the resident preferred. They also indicated that when the ADL documents were blank it was because nothing was completed.

Inspector #542 interviewed RPN #113 who indicated that they worked on a specific day shift in October 2017 on a different unit and an evening shift on another unit as the home was short staffed. They indicated that when they work short staffed, typically the scheduled baths/showers were not completed and bed baths were

provided to the residents instead.

On November 2, 2017, Inspector #542 interviewed PSW #136 who also worked on a specific day in October, 2017, on a different unit. They indicated that only one shower was provided and the rest were not completed, again, due to short staffing.

Inspector #542, interviewed PSW #137 who was scheduled to work a shift in October, 2017, on a specific unit but was transferred to another unit as that unit was also short staffed. They indicated that residents were provided with bed baths instead of their scheduled showers/baths because they were working short. Inspector #542 asked what a bed bath consisted of. They described it as being a very quick wipe down, more like morning and bedtime care.

Inspector #542 interviewed PSW #138 who worked on a specific unit in October, 2017. They indicated that they were unable to complete any of the showers or baths on that unit as they were working short PSW staff. They indicated that they were instructed to complete bed baths on all of the residents that were scheduled for a bath or shower that day. The bed bath consisted of basic care, like morning and bedtime care and not a real bed bath as they did not have the time.

Inspector #542 interviewed RPN #121 who also worked on the same day and unit as above. They indicated that it was a difficult shift as they were short PSW staff. They indicated that they were instructed to inform the PSWs to provide bed baths to the residents that were scheduled to have their bath or shower that day. Inspector #542 asked why resident #022 received a bed bath on a specific day in October, 2017. RPN #121 verified that it was because they did not have enough staff or time.

On November 2, 2017, Inspector #542 reviewed resident #022's care plan under the bathing heading. It was documented that resident #022 would be showered twice a week and that they preferred to be showered.

On November 2, 2017, Inspector #542 interviewed PSW #139 who worked during the day shift over a weekend in October, 2017, on a specific unit. PSW #139 indicated that resident #023 received a bed bath as they had not had enough time to provide them with a bath or a shower, as a result of short staffing.

Inspector #542 reviewed the health care record for resident #023 and noted that

their current care plan indicated that resident #023 was to receive a shower with one staff assist.

Inspector #542 spoke with PSW #140, who also worked over a specific weekend in October, 2017, on a different unit. They indicated that they were unable to complete the baths and showers, as they had not had enough staff or time.

On November 3, 2017, Inspector #542 interviewed RN #120 who worked during the day shift, over a specific weekend in October, 2017. RN #120 indicated that the whole building was short PSW staff. The Inspector asked what the procedure was when the home was that short staffed. RN #120 indicated that they notified the Director of Care (DOC) and they were instructed to inform the staff to complete bed baths. RN #120 indicated that they were worried as they knew some of the family members would be upset to know that their loved ones had not received their scheduled bath or shower; therefore, they wanted to verify with management that it was okay. [s. 33. (1)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint was submitted to the Director in October, 2017, outlining numerous concerns indicating that residents were not receiving a between-meal beverage. The complainant stated that their family member, resident #038 resided on a specific unit in the home.

On November 1, 2017, Inspector #542 interviewed PSW #135 who indicated that the home often worked without a full complement of PSWs and that they were often not able to provide the residents with the scheduled nourishments and beverages.

Inspector #542, interviewed PSW #137 who was scheduled to work in October, 2017 on a specific unit but was transferred to another unit as that unit was also short staffed. PSW #137 indicated that they were unable to complete the nourishment/beverage round for the residents due to being short staffed. In a subsequent interview with PSW #138, who worked on a different unit in October, 2017, they indicated that they were unable to provide the residents with the morning beverages during the nourishment round due to working short staffed. PSW #138 indicated that the residents that had a labelled nourishment were the only ones that received anything.

On November 2, 2017, Inspector #542 reviewed the nourishment/beverage documentation on another unit, over a two day period. Inspector reviewed nine different resident nourishment documentation (resident #025, #026, #027, #028, #029, #030, #031, #032 and #033) and found that they were all blank for both days.

On November 2, 2017, Inspector #542 interviewed PSW #139 who worked over a weekend in October 2017, on another unit another unit. They verified that the nourishment were not completed during the day shift.

On November 3, 2017, Inspector #542 received a phone call from a family member for resident #024. The family member indicated that the home did not have

enough PSWs to complete the care, including handing out the nourishments because they were short staffed.

On November 7, 2017, Inspector #542 observed on the unit where resident #038 resided and noted that PSW #117 was not documenting any fluid intake on the "resident daily food and fluid intake" record under the, "Nourishment AM" section for each resident. Inspector #542 asked PSW #117 if the 1000 hour (hr) beverages where provided to the residents. PSW #117 indicated that they had not had the time to provide the residents with the 1000 hr beverages. Inspector #542 spoke with PSW #149 who also confirmed that they were unable to provide the 1000 hr scheduled beverages to the residents. PSW #117 and PSW #149 verified that the blank documents indicated that the task was not completed.

On November 7, 2017, Inspector #542 reviewed the "resident daily food and fluid intake" record for resident #038. It was noted that for three days in November, 2017, there was no documentation to indicate that resident #038 had received any fluids during the morning nourishment. Inspector #542 also reviewed resident #042, #043, #044, #045, #046 and #047's "daily food and fluid intake" records and noted that nothing was documented for the three days in November, 2017, under the morning nourishment. [s. 71. (3) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a response was made to the person who made the complaint with in 10 business days of the receipt of the complaint.

Inspector #613 reviewed a complaint that was received by the Director in August, 2017, regarding resident #002. The complainant identified concerns related to the transferring technique of resident #002.

During an interview with the complainant, they reported that a staff member had informed them of this incident and that it had also happened in the past. The complainant stated they had reported their concern regarding resident #002's care and safety to the Assistant Director of Care (ADOC) #102; however, they had not heard a response back from management.

A review of the home's policy titled, "Complaints and Customer Service" last revised April 2017, identified that the home would proactively address and resolve concerns/complaints in a timely manner, in keeping with the principles of customer service, quality improvement and risk management. The home would provide a written response at the conclusion of their investigation to identify what the home had done to resolve the complaint and, the resulting information would be shared with the complainant.

During an interview on October 31, 2017, with the Assistant Director of Care (ADOC), they indicated they were aware of some of the details about the incident but had not dealt with it; identifying that, they had notified the Acting ADOC #103 and the Administrator of the occurrence, furthermore, they indicated that they had not followed through with the investigation and that the Acting ADOC or the

Administrator would have dealt with it. The ADOC indicated they did not recall speaking to the complainant.

2) Inspector #613 reviewed a complaint that was received by the Director in May, 2017, regarding resident #003, alleging the home had not informed them of resident #003's wound status and concerns regarding the provisions of care and assessments.

During an interview with the complainant, they reported that they had a meeting with the former Director of Care (DOC) in May, 2017, to report their provision of care concerns and not being informed of resident #003's wound status. The complainant indicated that the former DOC had not responded back to their complaint.

During an interview on November 1, 2017, with Acting ADOC #103, they indicated they were unaware of the complaints regarding resident #002 and #003 and that they had not spoken to the complainants. The Acting ADOC stated they had reviewed the complaint file and there was no reference to the verbal complaints and there had been no follow up response back to the complainants. The Acting ADOC further indicated that they had spoken to ADOC #102, who did not recall the incidents, but they were now aware to follow up with verbal and written complaints. Acting ADOC #103 verified that the complainants had not been responded back to in a timely manner. [s. 101. (1) 3.]

Additional Required Actions:

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

WN #5: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

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

A complaint was submitted to the Director regarding care concerns of resident #001. The complainant alleged that resident #001 was found in bed on multiple occasions while the breakfast meal service was being provided. The complainant indicated that resident #001 preferred to attend the breakfast meal service.

Inspector #638 reviewed resident #001's care plan and identified an intervention which was created in August, 2017, directed staff to ensure that the resident was up and in the dining room for breakfast each morning. The Inspector reviewed resident #001's "Plan of Care" which was kept in the PSW binder and identified that the resident liked to sleep in and to always ask if they wanted to get up, and if not, let the resident stay in bed.

In an interview with Inspector #638, PSW #123 indicated that the PSWs refer to the resident's care plan or "Plan of Care" document for resident specific information. The Inspector reviewed the "Plan of Care" document and the care plan with PSW #123 who indicated that the morning care needs were conflicting and could cause confusion depending on what staff referred to.

During an interview with Inspector #638, RPN #124 indicated that the direct care staff refer to the resident's care plan "Plan of Care" document for resident specific information. The RPN further indicated that whenever a resident's care needs changed the PSWs would notify registered staff, who would then update the plan. The Inspector reviewed the care plan and "Plan of Care" document with the RPN who indicated that it appeared as though the "Plan of Care" document was the care the resident was receiving while they were residing a specific unit and as the resident was not supposed to be up in the morning, the document should have been updated to demonstrate the resident's current needs.

In an interview with Inspector #638, the Administrator, Acting DOC and Clinical Consultant indicated that staff were to refer to the resident's care plan for specific care interventions. The Inspector reviewed the "Plan of Care" document found in the PSW flow sheet binder and they indicated that this document should not have been in the resident's flow sheet binder as this was not the home's process; however, if staff referred to this document it could have caused confusion as to what the resident's true care needs were. [s. 6. (1) (c)]

2. A complaint was submitted to the Director in October, 2017, by a family member for resident #038. The complainant indicated that they were concerned that resident #038 was being provided with the incorrect diet texture by the staff because the resident takes a long time to consume their meals.

On November 7, 2017, Inspector #542 reviewed resident #038's current plan of care. The care plan indicated that they required assistance at meals. It was also documented to provide the resident with a regular diet, in a specific texture and that they may require different textures as needed. At supper, resident #038 was to receive regular textured foods as a family member would assist them.

On November 8, 2017, Inspector #542 interviewed PSW #148 with regards to resident #038's diet texture. PSW #148 reviewed the diet list behind the servery which outlined that the resident was to receive a specific textured diet at breakfast and lunch and a regular textured diet at supper. PSW #148 indicated that resident #038 required quite a bit of time to consume their meals.

On November 8, 2017, Inspector #542 observed resident #038 in the dining room at breakfast at 0930 hours. Inspector #542 noted that the resident had regular toast with crust, a poached egg and a specific texture of fruit and had consumed a small portion of their meal. PSW #117 was assisting the resident with their meal.

PSW #117 was unsure as to why the resident had foods of different textures on their plate but thought that it was a family request.

On November 9, 2017, Inspector #542 interviewed the Registered Dietitian (RD). The RD indicated that the only reason that the "specific" texture was on resident #038's care plan was to ensure that the dietary department made enough. They denied that resident #038 had any swallowing difficulties and that the food texture was ordered because the resident would often take a long time to consume their meals and then would become tired, thus not meeting caloric requirements. They also acknowledged that the care plan was unclear and indicated that they would update it to reflect that the resident was to receive a specific texture at breakfast and lunch and a regular textured diet at supper. The RD was unsure why the staff were providing two different textures at meals. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Inspector #613 reviewed a complaint that was received by the Director in May, 2017, regarding resident #003, alleging that the home had not informed them of resident #003's wound status and concerns regarding the provisions of care and assessments.

During an interview with the complainant, who was the resident's substitute decision-maker (SDM), they informed the Inspector that they had not been made aware of resident #003's wound status, until the resident had been hospitalized approximately a month later.

A review of the progress notes on Point Click Care (PCC) did not reveal documentation that resident #003's SDM had been notified of the wound status or provided the opportunity to participate in the resident's wound plan of care.

During interview on October 31, 2017, with RPN #101, they revealed that the registered staff were expected to notify the resident's SDM for all changes regarding a resident's health status, including wound status and to document the notification in the progress notes on PCC, as per the home's policy. RPN #101 reviewed resident #003's progress notes on PCC and was unable to locate documentation that the family had been kept informed of the wound status and

treatment. RPN #101 indicated that the home had failed to keep the family informed of changes related to the resident's wound status.

A review of the home's policy, "A review of policy titled, "Notification of Family/Substitute Decision Maker" last revised April 2017, identified the nurse/interdisciplinary team would notify the SDM/POA when there had been a significant change in medical health, or condition that could negatively impact the resident's comfort or well- being, changes in their care or treatment plan and to document consent/refusal in the progress notes.

During an interview with Acting Assistant Director of Care (Acting ADOC) #103, they verified that the registered staff were expected to inform the SDM's of all resident health status and care changes. The Acting ADOC indicated that the staff should have kept family informed of resident #003's wound status, whether deterioration or improvement. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for each resident set out clear directions to staff and others who provide direct care to the resident and ensure that the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

A complaint was submitted to the Director regarding care concerns of resident #001. The complaint alleged that resident #001 had not received foot care for approximately nine months.

Inspector #638 reviewed resident #001's health care records and identified in their current care plan that resident #001 required "Nursing Foot Care - Advanced" which was initially created in March, 2015. The health care records further identified in the census record that resident #001 resided on a specific unit and was transferred to another unit in November, 2016. The resident's medical diagnoses identified the resident was also a diabetic.

The home's policy titled "Nail and Foot Care - RC-06-01-04" last updated April 2017, indicated that all residents were to have their fingernails, toenails and feet checked at the time of their bath and care provided according to their needs and preferences. The policy further indicated that the nurse was to provide foot care to residents with diabetes when a qualified foot care provider was unavailable.

During an interview with Inspector #638, PSW #122 indicated that PSWs completed a weekly head to toe assessments for residents to monitor for changes. These assessments included a thorough skin and nail assessment. If there were any concerns they would report this to registered staff who would follow up with the concerns identified.

In an interview with Inspector #638, RPN #121 indicated that resident #001 previously resided on a different unit, where they received foot care periodically

(approximately every six to eight weeks on average). The RPN indicated that the resident was moved to the current unit a while ago and the resident went an extended period of time without any foot care due to a miscommunication during the transfer. The RPN identified that the resident received foot care for the first time since their transfer to the current unit in July, 2017, once the resident's family identified the concern.

During an interview with the Administrator, Acting DOC and Clinical Consultant, they indicated to the Inspector that PSWs were required to monitor resident's skin integrity and nails at least weekly on bath days and if concerns were identified, they would report to registered staff. The Administrator and Acting DOC, that foot care should have been provided to meet the resident's needs. [s. 35. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

WN #7: 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.

Two complaints were submitted to the Director, one in September, 2017 and one in October, 2017, outlining concerns related to the care plan not being followed for resident #005.

Inspector #642 reviewed resident #005's health care records and the current care plan dated October, 2017, under the focus heading for transfers, the care plan, stated, "requiring assistance by two staff via sit to stand or overhead lift for transfers."

Inspector #642 interviewed the complainant on October 27, 2017, who stated that they had placed a video camera in resident #005's room and had provided the Long Term Care (LTC) home with the video recordings.

Inspector #642 reviewed the one minute video recording that the LTC home had for the specific dates in question. In the video recording dated for the morning of a specific day in 2017, PSW #106 went into resident #005's room on the resident's bath day. PSW #106 placed the resident in a transfer sling, then left the room. Then PSW #130 came into resident #005's room proceeded to transfer resident #005 out of their bed with the use of a lift and placed them in their chair, without the assistance of another staff member.

Inspector #642 reviewed the LTC home's video recording, for a different day in 2017. During resident #005's morning care, they requested a specific toileting intervention from PSW #133. PSW #133 provided resident #005 with a different toileting intervention. PSW #133 then proceeded to transfer resident #005 up into a sitting position and then placed the resident on a lift without another staff members assistance. PSW #133 then brought resident #005 out of the bathroom and placed them into their chair using the lift without another staff members assistance.

The Inspector reviewed the home's policy titled, "Mechanical Lifts, LP-01-01-02, last updated April 2017," under policy, it stated, "when the resident assessment indicated that a mechanical lift was required, staff were to follow the established procedure and use approved mechanical lifting equipment. Two trained staff were required at all times when performing a mechanical lift transfer. The mechanical lift included, a full lift, ceiling lift, sit-to-stand lift, and a tub lift."

Inspector #642 interviewed PSW #112, on November 1, 2017, and PSW #131 and

RN #128 on November 3, 2017, all indicated that it was a requirement to have two staff present when transferring a resident with a mechanical lift.

The Inspector interviewed the DOC and the Administrator on November 3, 2017 and they indicated that it was a requirement to have two staff members present when they were transferring residents with the mechanical lifts. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors kept closed and locked when they were not being supervised by staff.

On November 2, 2017, at 0903 hours Inspector #638 observed on a specific unit, that a tub room door was propped open with a care cart with no direct care staff in the vicinity as they were attending the breakfast meal service.

In an interview with Inspector #638, PSW #126 indicated that they may have left the tub room door open when they pushed the care cart into the tub room earlier. They indicated that the cart may have been caught on the door when they walked away. The PSW indicated that the tub room doors should have been kept closed and locked when not supervised, for resident safety.

During an interview with the Administrator, Acting DOC and Clinical Consultant, the Inspector reviewed the incident where the tub room door was left open and unsupervised. They indicated that all non-resident areas should be kept closed and locked when not in use for resident safety. [s. 9. (1) 2.]

Issued on this 12 day of February 2018 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SHELLEY MURPHY (684) - (A2)

Inspection No. / No de l'inspection : 2017_616542_0018 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 009278-17, 009403-17, 009984-17, 014753-17, 016183-17, 017893-17, 018569-17, 021998-17, 022955-17, 023028-17, 023566-17, 024698-17, 024752-17 (A2)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Feb 12, 2018;(A2)

Licensee / Titulaire de permis : Extendicare (Canada) Inc.
3000 Steeles Avenue East, Suite 700, MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD : Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue, SAULT STE. MARIE, ON, P6B-4J3

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Carly Brown

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To Extendicare (Canada) 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (1) This section and sections 32 to 47 apply to,
(a) the organized program of nursing services required under clause 8 (1) (a) of the Act; and
(b) the organized program of personal support services required under clause 8 (1) (b) of the Act. O. Reg. 79/10, s. 31 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan in order to be in compliance with O. Reg. 79.10, s. 31 (1). The plan shall include but is not limited to;

a) a detailed description of how the licensee will develop and implement consistent strategies to recruit and retain direct care staff in order to provide residents with quality care as per their care plans,

b) a detailed description of how the licensee will ensure that the care needs of the residents are being met regardless of the home`s staffing levels. Specifically but not limited to, bathing and showering preferences, providing scheduled nourishments and preferred wake time,

c) a plan that details how the licensee will review the specific care needs of the residents on each unit to determine the staffing pattern for all units based on the assessed needs of the residents and

d) how the licensee plans to ensure that the organized program of personal support services is reviewed, how often and who will participate in the review. The review shall be documented and shall include any changes made to the organized program.

Please submit the plan by January 26, 2018, in writing, to Jennifer Lauricella, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Long-Term Care Inspections Branch, Long-Term Care Homes Division, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Inspector #542 reviewed numerous complaints that were submitted to the Director outlining concerns that the home was not meeting the needs of the residents. The complainants all indicated that the home was often working without a full complement of Personal Support Workers (PSWs) and that residents were not receiving their scheduled baths or showers, scheduled nourishments, toileting needs, skin

assessments and repositioning as per their care plans.

On October 31, 2017, and on November 6, 2017, Inspector #542 interviewed scheduling clerk #105, #143 and #144. They were asked to provide the Inspector with documentation that indicated when and where the home was working without a full complement of PSW staff. Inspector #542 reviewed the documentation and noted that during a five week period in 2017, the home was short three or more PSWs on seven separate occasions on various units throughout the home. Furthermore, during a weekend in October 2017, during a day shift, the home was short six PSWs on both days.

On October 30, 2017, Inspector #542 reviewed resident #035's progress notes and found that on a specific day in August, 2017, it was documented that they did not receive their shower due to a staffing situation. Inspector #542 reviewed the document that was provided by scheduling clerk #105 which verified that the home was short 6 PSWs that same day in August, 2017.

On November 1, 2017, Inspector #542 reviewed the Activity of Daily Living (ADL) documentation for resident #036 who resided on a specific unit. It was noted that during a seven day period in October, 2017, there was no documentation under the bathing heading to indicate that the resident had received their bath/shower for that week. A review of the head to toe skin assessments revealed that the last assessment was completed in October, 2017. The bath/shower assignment document had resident #036 listed for one shower/bath a week, during the day on Saturdays. A review of the current care plan revealed that resident #036 was to receive a bath/shower twice a week.

On November 1, 2017, Inspector #542 interviewed PSW #106 who worked the unit where resident #036 resided, for two days in October, 2017, during the day shift and then accepted an evening overtime shift on one of those days on a different unit. PSW #106 indicated that it was very difficult to complete all care for the residents as they were working short PSW staff. PSW #106 verified that they were unable to complete some of the baths for the residents on the specific unit for both day shifts. PSW #106 also indicated that during the evening shift on the other unit, they were also unable to complete the baths/showers for the residents.

Inspector #542 interviewed PSW #114 who worked on the same weekend in October, 2017, during the evening shift on the same unit that resident #036 resided

on. They indicated that they tried their best to complete all of the care for the residents; however, as a result of being short staffed, they were unable to complete showers for resident #020 and #021. Inspector #542 asked if there was any other resident care that was impacted by working without a full complement of PSWs. PSW #114 indicated that residents had to wait longer for assistance, and nourishment was not always provided to the residents. They indicated that it was very difficult to complete the care.

Inspector #542 reviewed the ADL document, under the bathing section for resident #020, who resided on the same unit as above and noted that there was no documentation that indicated that resident #020 had received their scheduled bath on a specific day in October, 2017. A review of the head to toe skin assessments also revealed no documentation that indicated that this was completed. A review of the current care plan for resident #020 revealed that they preferred to be showered and required assistance by one staff.

Inspector #542 reviewed the health care record for resident #021, who also resided on the same unit. The bathing assignment document indicated that resident #021 was to receive their shower on a specific evening in October, 2017. The ADL document from the specific evening in October, did not indicate that the resident received their shower but rather a bed bath. A review of resident #021's current care plan verified that they preferred showers and required assistance by one staff member and two staff for transfers.

On November 1, 2017, Inspector #542 interviewed PSW #135. They indicated that they frequently worked without a full complement of PSW staff and that it was impossible to complete all of the required care for the residents. PSW #135 indicated that at times they were unable to deliver the scheduled nourishments to the residents and that they had to complete bed baths even if this was not what the resident preferred. They also indicated that when the ADL documents were blank it was because nothing was completed.

Inspector #542 interviewed RPN #113 who indicated that they worked on a specific day shift in October 2017, on a different unit and an evening shift on another unit as the home was short staffed. They indicated that when they work short staffed, typically the scheduled baths/showers were not completed and bed baths were provided to the residents instead.

On November 2, 2017, Inspector #542 interviewed PSW #136 who also worked on a specific day in October, 2017, on a different unit. PSW #136 indicated that the nourishments were not provided to the residents on that unit as they were too short staffed. They indicated that only one shower was provided and the rest were not completed, again, due to short staffing.

Inspector #542, interviewed PSW #137 who was scheduled to work a shift in October, 2017 on a specific unit but was transferred to another unit as that unit was also short staffed. They indicated that residents were provided with bed baths instead of their scheduled showers/baths because they were working short. Inspector #542 asked what a bed bath consisted of. They described it as being a very quick wipe down, more like morning and bedtime care. PSW #137 also indicated that all residents on the unit had not received their nourishment.

Inspector #542 interviewed PSW #138 who worked on a specific unit in October, 2017. They indicated that they were unable to complete any of the showers or baths on that unit as they were working short PSW staff. They indicated that they were instructed to complete bed baths on all of the residents that were scheduled for a bath or shower that day. The bed bath consisted of basic care, like morning and bedtime care and not a real bed bath as they did not have the time. PSW #138 indicated that they provided some of the nourishment but not all, due to short staffing.

Inspector #542 interviewed RPN #121 who also worked during the same day and unit as above. They indicated that it was a difficult shift as they were short PSW staff. They indicated that they were instructed to inform the PSWs to provide bed baths to the residents that were scheduled to have their bath or shower that day. Inspector #542 asked why resident #022 received a bed bath on a specific day in October, 2017. RPN #121 verified that it was because they did not have enough staff or time.

On November 2, 2017, Inspector #542 reviewed resident #022's care plan under the bathing heading. It was documented that resident #022 would be showered twice a week and that they preferred to be showered.

On November 2, 2017, Inspector #542 interviewed PSW #139 who worked during the day shift over a weekend in October, 2017, on a specific unit. PSW #139 indicated that resident #023 received a bed bath as they had not had enough time to

provide them with a bath or a shower. PSW #139 also verified that the nourishments, two hour toileting routines and shaving were not completed for the residents on the unit that they worked on as they did not have a full complement of PSW staff.

Inspector #542 reviewed the health care record for resident #023 and noted that their current care plan indicated that resident #023 was to receive a shower with one staff assist.

Inspector #542 spoke with PSW #140, who also worked over a specific weekend in October, 2017, on a different unit. They indicated that they were unable to complete the baths and showers, as they had not had enough staff or time.

On November 1, 2017, Inspector #542 interviewed PSW #135 who indicated that the home often worked without a full complement of PSWs and that they often were not able to provide the residents with the scheduled nourishments and beverages.

On November 2, 2017, Inspector #542 interviewed PSW #137 who worked a day shift on a different unit on a specific day in October, 2017. PSW #137 indicated that they were unable to complete the nourishment/beverage round for the residents due to being short staffed.

Inspector #542 interviewed PSW #138 who worked on another unit, on a specific day in October, 2017. PSW #138 indicated that they were unable to provide the residents with the morning beverages during the nourishment round due to short staffing. PSW #138 indicated that the residents that had a labelled nourishment were the only ones that received anything.

On November 2, 2017, Inspector #542 reviewed the nourishment documentation from, October 28 and 29, 2017, on a specific unit for nine different residents (resident #025, #026, #027, #028, #029, #030, #031, #032 and #033). There was no documentation to support that any intake was consumed on either day with regards to the day time nourishment passes at 1000 hrs and 1400 hrs.

On November 3, 2017, Inspector #542 interviewed RN #120 who worked during the day shift, over a specific weekend in October, 2017. RN #120 indicated that the whole building was short PSW staff. The Inspector asked what the procedure was when the home was that short staffed. RN #120 indicated that they notified the

Director of Care (DOC) and they were instructed to inform the staff to complete bed baths. RN #120 indicated that they were worried as they knew some of the family members would be upset to know that their loved ones had not received their scheduled bath or shower; therefore, they wanted to verify with management that it was okay. RN #120 indicated that the care of the residents suffered because they were short staffed, toileting routines and bathing schedules were not followed, also the residents had to wait a lot longer for assistance. At times, residents were brought to the dining rooms in their pajamas because of being short staffed; furthermore, PSW staff were running late getting to the dining room for meals due to not enough staff. They indicated that it was very upsetting that they could not always provide the care that the residents deserved.

On November 3, 2017, Inspector #542 was approached by resident #019. Resident #019 indicated that the home did not have enough staff and that the management team always said they were working on it but it just did not seem to be improving. Resident #019 indicated that sometimes they had to wait a long time for assistance with care and that they missed their baths because there was not enough staff. They also indicated that quite often they were late for meals and that there was not enough staff to assist the residents.

Inspector #542 spoke with a family member of resident #024, who expressed concerns regarding the staffing levels in the home. They indicated that there were times when resident #024 had juice in their room from the evening before and the staff were unable to give the resident nourishment during the day as they were short staffed. The family member also indicated that resident #024's bed linens and clothing were often soiled because they were short staffed.

On November 3, 2017, Inspector #542 reviewed the progress notes for resident #024. On a specific day in October, 2017, it was documented that resident #024 was yelling as they needed assistance to use the bathroom. Resident #024 informed the RN that there was not enough staff in the building to assist the residents. In a subsequent progress note, documented also in October, 2017, a family member for resident #024 called and informed the staff that they had noticed that resident #024 would ring for assistance and that it would take a long time for staff to respond.

On November 7, 2017, Inspector #542 observed on a specific unit and noted that PSW #117 was not documenting any fluid intake on the "resident daily food and fluid intake" record under the, "Nourishment AM" section for each resident. Inspector

#542 asked PSW #117 if the 1000 hours (hrs) beverages where provided to the residents. PSW #117 verified that they had not had the time to provide the residents with the 1000 hr beverages. Inspector #542 spoke with PSW #149 who also confirmed that they were unable to provide the 1000 hr scheduled beverages to the residents. PSW #117 and PSW #149, verified that blank documents indicated that the task was not completed.

On November 7, 2017, Inspector #542 reviewed the "resident daily food and fluid intake" record for resident #038. It was noted that for three days in November, 2017, there was no documentation to indicate that resident #038 had received any fluids during the am nourishment. Inspector #542 also reviewed resident #042, #043, #044, #045, #046 and #047's "daily food and fluid intake" records and noted that nothing was documented for the same three days in November, 2017, under the morning nourishment.

Inspector #542 observed that some of the residents were not present in the dining room during breakfast on a different unit. Inspector #542 interviewed PSW #117 who indicated that they were unable to get some of the resident's up into the dining room for breakfast as they had not had enough time. Resident #051, #052 and #053 were not present in the dining room for breakfast. PSW #117 also indicated that resident #046 and #054 were in the dining room in their pajamas because they had not had enough time to finish their morning care. Inspector #542 reviewed resident #051's current care plan and noted that it was documented that they got up around 0800 hrs. Resident #053's care plan indicated that their usual wake time was at 0800 hrs. Resident #046 and #054's care plan did not indicate that they preferred to be dressed in their pajamas for breakfast.

Inspector #638 reviewed a complaint submitted to the Director related to staffing concerns within the home. The complaint outlined an incident on a specific day in October, 2017, where family came to visit resident #001 and found the resident still in bed at approximately 1010 hours. The complaint alleged that they were notified by staff that the facility was short staffed and that "we couldn't get everyone up for breakfast" and "we do our best, but this company will not provide enough staff".

Inspector #638 reviewed resident #001's care plan and identified an intervention under the "Sleep and rest" foci that staff were to ensure that resident #001 was up and in the dining room for breakfast each morning.

In an interview with Inspector #638, RPN #129 indicated that when a home area was short staffed it was common that some residents were not up for breakfast. They indicated this was because there was not enough staff available to provide care to each resident and ensure they were up in time for breakfast. The RPN indicated that they met with family regarding resident #001's concerns and indicated that they were short staffed and unable to ensure that the resident was up for breakfast.

During an interview with Inspector #638, RN #128 indicated that when the home was short staffed, the biggest issue was ensuring that all residents were up in the morning. The RN indicated that the direct care staff attempt to get everyone up for breakfast; however, this was not always possible due to the lack of available staff. The RN indicated that it was "probably valid" that they were too short sometimes to ensure that everyone who should have been up was up.

Inspector #542 interviewed the Administrator, Director of Care (DOC) and the Acting Assistant Director of Care (AADOC). Inspector #542 asked what the procedure was for calling in staff. The Administrator indicated that the scheduling clerk would inform the management team on Friday as to how the home was scheduled for the weekend. Also they would call the manager on call on the weekend if they were short staffed. The Administrator indicated that they had been having staffing issues since the summer and that the home has a contract with the "Plan A Agency" for assistance with filling some of the vacant shifts. Inspector #542 asked when the home started reviewing the home's staffing plan. They indicated that they have been reviewing the staffing plan for approximately two weeks now. The Administrator indicated that when they were really short staffed, that they would call in extra staff the next day to assist; they have also had other support services staff come in and assist with feeding and other duties other than care related duties. Inspector #542 asked what occurred on the specific weekend in October, 2017, when the home was short six PSW's on both day shifts. The Administrator and the DOC indicated that they were not aware that the home was that short until Monday. Inspector #542 asked the Administrator what was done about it on Monday; they verified that nothing was done to address the staffing complements.

During a subsequent interview with the Administrator, Inspector #542 asked the Administrator if they felt that the home provided a staffing mix that was consistent with residents' assessed care and safety needs. The Administrator acknowledged that the home has had staffing problems during the weekends but felt that the home was well staffed from Monday to Friday. They indicated that approximately two

weeks ago they started reviewing a specific unit as they recognized that this unit was very heavy with the care needs. The Administrator expressed that the home was considering moving some of the residents from that unit to another unit in attempt to adjust the workload. Inspector #542 asked the Administrator if they felt that the home had an organized program of personal support services for the home to meet the assessed needs of the residents. The Administrator responded, "yes, during the week we are meeting the needs of the residents, for the most part." Inspector #542 explained that during this inspection it had been identified that the residents were not receiving their scheduled baths or showers and the scheduled nourishments. Inspector #542 asked the Administrator again if they felt that the home had an organized program of personal support services to meet the assessed needs of the residents. The Administrator indicated that they could not answer that question.

The decision to issue this Compliance Order (CO) was based on the scope which was determined to be widespread. Despite there being no previous compliance history with this area of the legislation, the severity was determined to be a potential for harm of the residents health and well-being. (542)

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

Feb 02, 2018

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that identifies how the licensee will be in compliance with O. Reg. 79/, s. 33 (1).

The plan shall include the following;

a) how the licensee will ensure that all residents are being offered a bath at a minimum of twice a week by their method of choice; and to be included in their plan of care and,

b) how the licensee will ensure that all direct care staff are trained on the home's procedure on how to complete a full bed bath.

Please submit the plan by January 26, 2018, in writing, to Jennifer Lauricella, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Long-Term Care Inspections Branch, Long-Term Care Homes Division, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5.

Grounds / Motifs :

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

On October 30, 2017, Inspector #542 reviewed resident #035's progress notes and found that on a specific day in August, 2017, it was documented that they did not receive their shower due to a staffing situation.

On November 1, 2017, Inspector #542 reviewed the Activity of Daily Living (ADL) documentation for resident #036 who resided on a specific unit. It was noted that

during a seven day period in October, 2017, there was no documentation under the bathing heading to indicate that the resident had received their bath/shower for that week. The bath/shower assignment document had resident #036 listed for one shower/bath a week, during the day on Saturdays. A review of the current care plan revealed that resident #036 was to receive a bath/shower twice a week.

On November 1, 2017, Inspector #542 interviewed PSW #106 who worked the unit where resident #036 resided. PSW #106 worked on the unit for two days in October, 2017, during the day shift and then accepted an evening overtime shift on one of those days on a different unit. PSW #106 indicated that it was very difficult to complete all care for the residents as they were working short PSW staff. PSW #106 verified that they were unable to complete some of the baths for the residents on the specific unit for both day shifts. PSW #106 also indicated that during the evening shift on the other unit on, they were also unable to complete the baths/showers for the residents.

Inspector #542 interviewed PSW #114 who worked on the same weekend in October, 2017 during the evening shift on the same unit that resident #036 resided on. They indicated that they tried their best to complete all of the care for the residents; however, as a result of being short staffed, they were unable to complete showers for resident #020 and #021. They indicated that it was very difficult to complete the care.

Inspector #542 reviewed the ADL document, under the bathing section for resident #020, who resided on the same unit as above and noted that there was no documentation that indicated that resident #020 had received their scheduled bath on a specific day in October, 2017. A review of the current care plan for resident #020 revealed that they preferred to be showered and required extensive assistance by one staff.

Inspector #542 reviewed the health care record for resident #021, who also resided on the same unit. The bathing assignment document indicated that resident #021 was to receive their shower on a specific evening in October, 2017. The ADL document from the specific day in October, did not indicate that the resident received their shower but rather a bed bath. A review of resident #021's current care plan verified that they preferred showers and required total assistance by one staff member and two staff for the transfer.

On November 1, 2017, Inspector #542 interviewed PSW #135. They indicated that they frequently worked without a full complement of PSW staff and that it was impossible to complete all of the required care for the residents. PSW #135 indicated that at times they had to complete bed baths, even if this was not what the resident preferred. They also indicated that when the ADL documents were blank it was because nothing was completed.

Inspector #542 interviewed RPN #113 who indicated that they worked on a specific day shift in October 2017 on a different unit and an evening shift on another unit as the home was short staffed. They indicated that when they work short staffed, typically the scheduled baths/showers were not completed and bed baths were provided to the residents instead.

On November 2, 2017, Inspector #542 interviewed PSW #136 who also worked on a specific day in October, 2017, on a different unit. They indicated that only one shower was provided and the rest were not completed, again, due to short staffing.

Inspector #542, interviewed PSW #137 who was scheduled to work a shift in October, 2017, on a specific unit but was transferred to another unit as that unit was also short staffed. They indicated that residents were provided with bed baths instead of their scheduled showers/baths because they were working short. Inspector #542 asked what a bed bath consisted of. They described it as being a very quick wipe down, more like morning and bedtime care.

Inspector #542 interviewed PSW #138 who worked on a specific unit in October, 2017. They indicated that they were unable to complete any of the showers or baths on that unit as they were working short PSW staff. They indicated that they were instructed to complete bed baths on all of the residents that were scheduled for a bath or shower that day. The bed bath consisted of basic care, like morning and bedtime care and not a real bed bath as they did not have the time.

Inspector #542 interviewed RPN #121 who also worked on the same day and unit as above. They indicated that it was a difficult shift as they were short PSW staff. They indicated that they were instructed to inform the PSWs to provide bed baths to the residents that were scheduled to have their bath or shower that day. Inspector #542 asked why resident #022 received a bed bath on a specific day in October, 2017. RPN #121 verified that it was because they did not have enough staff or time.

On November 2, 2017, Inspector #542 reviewed resident #022's care plan under the bathing heading. It was documented that resident #022 would be showered twice a week and that they preferred to be showered.

On November 2, 2017, Inspector #542 interviewed PSW #139 who worked during the day shift over a weekend in October, 2017, on a specific unit. PSW #139 indicated that resident #023 received a bed bath as they had not had enough time to provide them with a bath or a shower, as a result of short staffing.

Inspector #542 reviewed the health care record for resident #023 and noted that their current care plan indicated that resident #023 was to receive a shower with one staff assist.

Inspector #542 spoke with PSW #140, who also worked over a specific weekend in October, 2017, on a different unit. They indicated that they were unable to complete the baths and showers, as they had not had enough staff or time.

On November 3, 2017, Inspector #542 interviewed RN #120 who worked during the day shift, over a specific weekend in October, 2017. RN #120 indicated that the whole building was short PSW staff. The Inspector asked what the procedure was when the home was that short staffed. RN #120 indicated that they notified the Director of Care (DOC) and they were instructed to inform the staff to complete bed baths. RN #120 indicated that they were worried as they knew some of the family members would be upset to know that their loved ones had not received their scheduled bath or shower; therefore, they wanted to verify with management that it was okay.

The decision to issue this Compliance Order was based on scope which was determined to be widespread. Although the licensee did not have a compliance history within this area of the legislation, the severity was determined to have the potential for actual harm to the residents. (542)

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

Apr 06, 2018(A2)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to include;

a) how the licensee will ensure that all residents are offered a minimum, a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner despite the home's staffing levels.

b) an audit system that is documented to include how the home will ensure that residents are being offered the required beverages and snacks as per legislation.

Please submit the plan by January 26, 2018, in writing, to Jennifer Lauricella, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Long-Term Care Inspections Branch, Long-Term Care Homes Division, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5.

Grounds / Motifs :

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

A complaint was submitted to the Director in October, 2017, outlining numerous concerns indicating that residents were not receiving a between-meal beverage. The complainant stated that their family member, resident #038 resided on a specific unit in the home.

On November 1, 2017, Inspector #542 interviewed PSW #135 who indicated that the home often worked without a full complement of PSWs and that they were often not able to provide the residents with the scheduled nourishments and beverages.

Inspector #542, interviewed PSW #137 who was scheduled to work in October, 2017 on a specific unit but was transferred to another unit as that unit was also short staffed. PSW #137 indicated that they were unable to complete the nourishment/beverage round for the residents due to being short staffed. In a subsequent interview with PSW #138, who worked on a different unit in October, 2017, they indicated that they were unable to provide the residents with the morning beverages during the nourishment round due to working short staffed. PSW #138 indicated that the residents that had a labelled nourishment were the only ones that received anything.

On November 2, 2017, Inspector #542 reviewed the nourishment/beverage documentation on another unit, over a two day period. Inspector reviewed nine different resident nourishment documentation (resident #025, #026, #027, #028, #029, #030, #031, #032 and #033) and found that they were all blank for both days.

On November 2, 2017, Inspector #542 interviewed PSW #139 who worked over a weekend in October 2017, on another unit another unit. They verified that the nourishment were not completed during the day shift.

On November 3, 2017, Inspector #542 received a phone call from a family member for resident #024. The family member indicated that the home did not have enough PSWs to complete the care, including handing out the nourishments because they were short staffed.

On November 7, 2017, Inspector #542 observed on the unit where resident #038

resided and noted that PSW #117 was not documenting any fluid intake on the "resident daily food and fluid intake" record under the, "Nourishment AM" section for each resident. Inspector #542 asked PSW #117 if the 1000 hour (hr) beverages where provided to the residents. PSW #117 indicated that they had not had the time to provide the residents with the 1000 hr beverages. Inspector #542 spoke with PSW #149 who also confirmed that they were unable to provide the 1000 hr scheduled beverages to the residents. PSW #117 and PSW #149 verified that the blank documents indicated that the task was not completed.

On November 7, 2017, Inspector #542 reviewed the "resident daily food and fluid intake" record for resident #038. It was noted that for three days in November, 2017, there was no documentation to indicate that resident #038 had received any fluids during the morning nourishment. Inspector #542 also reviewed resident #042, #043, #044, #045, #046 and #047's "daily food and fluid intake" records and noted that nothing was documented for the three days in November, 2017, under the morning nourishment.

The decision to issue this Compliance Order (CO) was based on the scope which was determined to be widespread pattern of the staff not providing the residents with the scheduled beverages and snacks as per legislation. A previous Voluntary Plan of Correction (VPC) was issued on August 14, 2016 during inspection #2016_395613_0007. The severity was determined to have the potential to cause harm to the health and well-being of the residents.
(542)

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

Feb 02, 2018

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint, or

ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Order / Ordre :

The licensee shall ensure that a response is made to the person who made the complaint within 10 business days of the receipt of the complaint.

Grounds / Motifs :

1. The licensee has failed to ensure that a response was made to the person who made the complaint with in 10 business days of the receipt of the complaint.

1) Inspector #613 reviewed a complaint that was received by the Director in August, 2017, regarding resident #002. The complainant identified concerns related to the

transferring technique of resident #002.

During an interview with the complainant, they reported that a staff member had informed them of this incident and that it had also happened in the past. The complainant stated they had reported their concern regarding resident #002's care and safety to the Assistant Director of Care (ADOC) #102; however, they had not heard a response back from management.

A review of the home's policy titled, "Complaints and Customer Service" last revised April 2017, identified that the home would proactively address and resolve concerns/complaints in a timely manner, in keeping with the principles of customer service, quality improvement and risk management. The home would provide a written response at the conclusion of their investigation to identify what the home had done to resolve the complaint and, the resulting information would be shared with the complainant.

During an interview on October 31, 2017, with the Assistant Director of Care (ADOC), they indicated they were aware of some of the details about the incident but had not dealt with it; identifying that, they had notified the Acting ADOC #103 and the Administrator of the occurrence, furthermore, they indicated that they had not followed through with the investigation and that the Acting ADOC or the Administrator would have dealt with it. The ADOC indicated they did not recall speaking to the complainant.

2) Inspector #613 reviewed a complaint that was received by the Director in May, 2017, regarding resident #003, alleging the home had not informed them of resident #003's wound status and concerns regarding the provisions of care and assessments.

During an interview with the complainant, they reported that they had a meeting with the former Director of Care (DOC) in May, 2017, to report their provision of care concerns and not being informed of resident #003's wound status. The complainant indicated that the former DOC had not responded back to their complaint.

During an interview on November 1, 2017, with Acting ADOC #103, they indicated they were unaware of the complaints regarding resident #002 and #003 and that they had not spoken to the complainants. The Acting ADOC stated they had reviewed the complaint file and there was no reference to the verbal complaints and there had

been no follow up response back to the complainants. The Acting ADOC further indicated that they had spoken to ADOC #102, who did not recall the incidents, but they were now aware to follow up with verbal and written complaints. Acting ADOC #103 verified that the complainants had not been responded back to in a timely manner.

Although the home does not have a compliance history with this area of the legislation, the decision to issue this Compliance Order (CO) was based on the scope which was determined to be a pattern. The severity was determined to have the potential for harm to the residents. (613)

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

Feb 02, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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 12 day of February 2018 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SHELLEY MURPHY - (A2)

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

Service Area Office / Bureau régional de services : Sudbury